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HOSPITAL PROSPECTIVE PAYMENT SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

FEBRUARY 2, 1983

Part 1 of 2

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CONTENTS

Administration Witness

Page
Hon. Richard S. Schweiker, Secretary of Health and Human Services 15

Public Witnesses

Hon. Ron Wyden, Representative from Oregon 70
Michael D. Bromberg, executive director, Federation of American Hospitals 78
Federation of American Hospitals, Michael D. Bromberg 78
Dr. Mitchell Rabkin, president, Beth Israel Hospital, Boston, Mass 99
J. Alexander McMahon, president, American Hospital Association 125
American Hospital Association, J. Alexander McMahon 125
Crane, Robert M., director, Office of Health Systems Management, New York State Department of Health, Albany, N.Y 146
New York State Department of Health, Robert M. Crane 146
Charles F. Pierce, deputy commissioner of health, State of New Jersey, Trenton, N.J 157
New Jersey State Department of Health, Charles F. Pierce 157
Harold Cohen, executive director, Maryland Health Services Cost Review Commission 185
Maryland Health Services Cost Review Commission, Harold A. Cohen 185
Anderson, Dr. Ron, chief executive officer, Parkland Memorial Hospital for the National Association of Public Hospitals 216
National Association of Public Hospitals, Dr. Ron Anderson 216
Richard Fluke, executive director, Pennock Hospital, Hastings, Mich., chairman-elect, Michigan Hospital Association 245
Michigan Hospital Association, Richard Fluke 245

Additional Information

Press release 1
Background material by the committee staff 3
Opening statement of Senator Max Baucus 12
Prepared statement of:
    Hon. Richard S. Schweiker, Secretary of Health and Human Services 32
    Representative Ron Wyden of Oregon 73
    Michael D. Bromberg, Federation of American Hospitals 82
    Dr. Mitchell Rabkin, president of Boston's Beth Israel Hospital 103
    Association of American Medical Colleges, Dr. John A. D. Cooper, president 115
    J. Alexander McMahon, president, American Hospital Association 128
    Robert M. Crane, New York State Department of Health 149
    Charles F. Pierce, Jr., deputy commissioner, New Jersey State Department of Health 159
    Harold A. Cohen, executive director, Maryland Health Services Cost Review Commission 188
    Ron J. Anderson, M.D., for National Association of Public Hospitals 221
    Richard M. Fluke, chairman-elect, Michigan Hospital Association 248
Testimony of Louis P. Scibbetta, president, New Jersey Hospital Association 254

HOSPITAL PROSPECTIVE PAYMENT SYSTEM

WEDNESDAY, FEBRUARY 2, 1983

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:37 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Dole, Heinz, Baucus, Bradley, Long, Mitchell, and Pryor.

[The press release announcing the hearing, background material on the prospective payment system for medicare and the opening statement of Senator Max Baucus follow:]

[Press Release No. 83-101]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON HOSPITAL PROSPECTIVE PAYMENT SYSTEM PROPOSED BY SECRETARY SCHWEIKER

The Honorable Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold a hearing on the hospital prospective payment system proposed by the Department of Health and Human Services for a prospective payment system for the Government's largest health care program—medicare.

The hearing will begin at 9:30 a.m. on February 2, 1983 in Room SD-215 of the Dirksen Senate Office Building.

Senator Durenberger noted, "We are at a crossroads in national health policy. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provisions which extended the so-called 223 limits to ancillary service operating costs, modified the medicare reimbursement system to include case-mix adjustments, and related payments to a cost-per-case basis were the first step toward a payment system which would reward efficient providers of health care. TEFRA also required the Secretary of Health and Human Services to develop a medicare prospective payment proposal for hospitals, skilled nursing facilities, and other providers, and to report to the Congress on those proposals by December 31, 1982.

"Now that the Secretary's proposal has been reported, this hearing will provide our first opportunity to question Department officials as to the details of the proposal. Subsequently, we will call upon others to provide their views and concerns. I am sure there will be a great many issues to consider before we advocate implementation of a specific proposal."

The hearing schedule is as follows:

Part I—February 2, 9:30 a.m.: Administration Witness, Members of Congress.

Part II—February 16, 1:30 p.m.: State Health Officials, Hospital Associations; February 17, 9:30 a.m.: Health Care Providers, Consumer Groups; February 17, 1:30 p.m.: Health Insurers, Business Organizations.

"We are particularly interested in hearing comments with respect to construction of the diagnostic groupings used in a payment system based on case mix; data requirements; and a feasible implementation schedule. In addition, suggestions with respect to the treatment of capital costs and teaching costs would be welcomed," Senator Durenberger commented.

The Honorable Dave Durenberger (R., Minn.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that part II of the hearing on the hospital prospective payment system for medicare proposed by the Department of Health and Human Services, which was originally scheduled for February 16 and 17, 1983, has been rescheduled. Part I of the hearing will be held as originally scheduled. The revised schedule for part II of the hearing is as follows:

Part II—February 2, 1:30 p.m.: Hospital Associations, State Health Officials; February 17, 9:30 a.m.: Health Care Providers, Consumer Groups; February 17, 1:30 p.m.: Health Insurers, Business Organizations.

Witnesses who wish to testify on February 2, 1983 should submit their requests to be received no later than noon on January 20, 1983. Witnesses who wish to testify on February 17, 1983 have until February 3 to submit their requests.

The subject matter and location of the hearing will remain the same as originally announced.

BACKGROUND INFORMATION RELATING TO

MEDICARE HOSPITAL PROSPECTIVE PAYMENT PROPOSAL REPORTED TO THE CONGRESS

BY

SECRETARY RICHARD S. SCHWEIKER

DECEMBER 1982

Prepared by the Staff of the
SENATE COMMITTEE ON FINANCE
with the assistance of the
CONGRESSIONAL RESEARCH SERVICE

January 28, 1983

I. INTRODUCTION 1

II. CURRENT MEDICARE HOSPITAL REIMBURSEMENT 3

III. THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT (PPS) PROPOSAL 4

Payment rate computation method 5

Adjustments to the DRG rate 5

Exclusions from the prospective system 6

Inclusions in the prospective system 7

Recalibration of DRG prices 7

Administrative procedure 7

Effective date for implementation 8

IV. MAJOR ISSUES 8

I. INTRODUCTION

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required the Secretary of the Department of Health and Human Services to develop, in consultation with the Senate Finance Committee and the House Ways and Means Committee, medicare prospective payment proposals for hospitals, skilled nursing facilities, and to the extent feasible, other providers. The Secretary was directed to report to these committees on the proposals by December 31, 1982.

The following is a summary of the proposal for a prospective hospital payment system which was transmitted to the Committee in late December. Specific legislative language has not yet been provided.

II. CURRENT MEDICARE HOSPITAL REIMBURSEMENT

Currently, medicare reimbursement to hospitals is made according to a method which is known as "retrospective, cost-based" reimbursement. This means that medicare essentially pays hospitals for any reasonable costs which they incur in providing covered services to medicare beneficiaries. The important features of this method of reimbursement is that it is retrospective; i.e., payment is made for the costs of services which have already been provided. This type of system has long been viewed as inherently inflationary. It provides little or no incentive for hospitals to control costs or operate more efficiently, since the more costs a hospital incurs, the greater will be its medicare reimbursement.

The costs of hospital care have been increasing rapidly for many years. Since approximately 65 percent of medicare expenditures are for hospitals, such increases have serious financial implications for the Federal Government and for medicare beneficiaries. In FY 1967, medicare paid $3.2 billion for hospital services; in FY 1983, medicare will pay over $37 billion. Medicare expenditures for hospital care have increased 19 percent per year during the last 3 years.

In recognition of the inflationary aspects of the present cost-based retrospective reimbursement system, Congress recently approved changes in certain existing limits on medicare reimbursement to hospitals and added a new limit. Section 101(a)(1) of TEFRA provided the following:

1. Existing limits on reimbursement to hospitals (commonly known as Section 223 limits) were extended to cover all hospital inpatient operating costs. Previously, Section 223 limits covered just routine costs which represented approximately 40 percent of the hospital costs which

medicare reimbursed. A case-mix measure (an adjustment based on type of diagnosis) was incorporated into the formula for developing the limits, and the limits were changed to apply on a per discharge basis, rather than a per diem (per day) basis;

2. A new limit was added on the annual rate of increase in hospital inpatient costs per discharge; and

3. Incentive payments were added for hospitals whose costs would be below both of the limits.

The annual rate of increase limit and the incentive payment provision are applicable only to each hospital's first three cost reporting periods beginning on or after October 1, 1982. The expanded 223 limits were enacted without a similar sunset provision.

III. THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS) PROPOSAL

The medicare prospective payment system (PPS) proposal is the Department's plan to change the basis on which medicare payments to hospitals are made. Under this plan, the current cost-based method of reimbursement would be replaced by a fixed price method of payment by case. The Department would establish payment for inpatient hospital care at a predetermined rate for each type of medicare discharge in accordance with a Federal payment schedule for standard types of patient cases, according to diagnoses. The classification system used by the PPS proposal to group hospital inpatients according to their diagnoses is known as Diagnosis Related Groups (DRG's). Under the PPS proposal, rates would be established for each of the DRG's, and hospitals would be paid based on the DRG of the patient. The DRG system, developed at Yale University in the early 1970's, has been tested over a period of years and is now being used in New Jersey as the basis for hospital payment under the State's prospective payment system.

Under the DRG system, patients are categorized into one of 467 different groups, based on the specific principal diagnosis of the patient, the type of surgery, presence of specific complicating conditions, and patient age. Each DRG should then represent groupings of hospital inpatient cases with similar diagnoses, cases which would use similar resources in their treatment, and thus would represent similar costs. More complex types of cases such as kidney transplants (DRG 320) would receive a higher payment than simpler cases such as hernia repair (DRG 161). Certain types of cases with complications would receive a higher payment than cases without complications. Subject to certain adjustments, all hospitals would be paid the same amount for treating the same diagnosis.

PAYMENT RATE COMPUTATION METHOD

Hospitals would be paid a predetermined rate for each type of discharge in accordance with a Federal payment schedule for each DRG. The payment schedule would be calculated initially by using nationally collected data from: a 20 percent sample of medicare patient bills (called the MEDPAR file), medicare hospital cost reports, the medicare patient discharge file, and a wage index based on hospital wage information collected by the Bureau of Labor Statistics of the Department of Labor. The MEDPAR data file would be used to create a DRG Relative Price Index (a set of weights) that represents the relative costliness of treating different types of medicare cases (compared to the average cost per medicare case of all diagnoses). For example, craniotomy cases are 3.5 times as expensive as the average cost per medicare case, so the weight for the craniotomy DRG would be 3.5.

The medicare discharge file and the cost report file would be used to create a National Representative Cost per Discharge, which is the average cost per medicare case for all diagnoses, as if each hospital treated the average mix of patients, paid the national average wage rate, and had no teaching programs. The DRG Relative Price Index is a series of relative values, while the National Representative Cost per Discharge is a single dollar amount. When the DRG Relative Price Index values are multiplied by the National Representative Cost per Discharge, a set of National Standard DRG Prices is obtained. For example, if the National Representative Cost per Discharge were $3,000, then the price of DRG 1 (craniotomy) would be $3,000 x 3.5 = $10,500. In this way, 467 different prices, one for each DRG, would be calculated. The actual level of the prices initially will be determined within the constraint that the prospective payment system not increase medicare outlays over the amount that would be spent under the preset system of hospital reimbursement limits as modified by the 1982 Tax Act.

ADJUSTMENTS TO THE DRG RATE

The schedule of National Standard DRG Prices is adjusted for area wage differences using the Bureau of Labor Statistics' wage index (for about 300 areas) to create hospital area price schedules. The wage adjustment thus provides a separate payment schedule for each separate area of the Nation. All of the hospitals in a particular geographic area would be paid the same amount for the same type of case.

Indirect medical education costs would be estimated and reimbursed according to a "lump-sum payment", which would be separate and distinct from the DRG rate. The report indicates that this adjustment for indirect costs would be made in similar fashion to the methods currently used to adjust for indirect medical education costs under the existing Section 223 inpatient hospital operating cost limits.

Atypical cases, or "outliers", are cases which, although classifiable into a specific DRG, have an extremely short- or extremely long-length of stay relative to most cases in the same DRG. The PPS report indicates that medicare program data shows that each DRG contains a few atypical cases. The report indicates that the Department intends to pay the full DRG rate for all cases in a DRG, including unusually inexpensive cases. For unusually expensive cases, the full DRG rate would be paid plus an additional payment for the added services provided. Although the report states that the additional payment might be a percentage of charges for each day beyond the outlier cutoff point, it indicates that the actual percentage would be established after a careful review of available data. Additional payments would be provided only for approximately one-half of one percent of all cases identified as atypical long stays. In addition, the report indicates that the calculation of the rates for outliers would be balanced for the DRG rates in such a way as to be budget neutral, meaning that neither the payment method for outliers nor the particular definition of the outlier cutoff points should have any effect on the overall budget.

EXCLUSIONS FROM THE PROSPECTIVE SYSTEM

Types of Costs

The proposal indicates that (1) outpatient care, (2) capital expenses, and (3) direct medical education costs (such as salaries of interns and residents) would be "passed through" and would continue to be reimbursed separately on a reasonable cost basis.

There are a number of hospital items or services (such as radiology, laboratory, physical therapy, braces, etc.) which medicare permits hospitals to contract for from outside firms and the firms to bill the program separately for such items as "medical and other supplies" under part B of the program. Since separate billing is permitted, hospitals have an incentive to contract for these services in order to reduce their cost of inpatient care. The present cost limits as modified by TEFRA provide for adjustments to take into account a decrease in inpatient services from the levels which similar types of hospitals customarily furnish. The PPS report indicates that the Department intends to monitor this situation to make sure that medicare does not pay for the same service twice.

Types of Hospitals

(1) Long-term care hospitals, (2) psychiatric hospitals, (3) tuberculosis hospitals, and (4) pediatric hospitals would continue to be paid under the current retrospective cost-based reimbursement system.

The report indicates that the Department intends to begin research to develop DRG's based on treatment in psychiatric hospitals that would be used to bring these facilities into a prospective system in the future.

INCLUSIONS IN THE PROSPECTIVE SYSTEM

The Department included both health maintenance organizations (HMO's) and designated sole community providers (usually small rural hospitals) in the proposal. However, HMO's which enter into risk sharing contracts with the Department would be paid according to current statute, i.e., the per capita rate of 95 percent of the expected costs of providing similar services in the fee-for-service system, instead of being paid the prospective payment rate. The PPS report indicates that the Secretary would need the authority to make appropriate exceptions and adjustments to the DRG rates for the hospitals which are designated sole community providers.

RECALIBRATION OF THE DRG PRICES

The Department would have to deal with two types of recalibration of the DRG prices: changes in the level of DRG prices (as the National Standards Cost per Case changes) and changes in the structure of relative prices across DRG's (as represented by the DRG Relative Price Index). The PPS report indicates that changes in the DRG prices may be needed, perhaps as often as annually to respond to changes in the increases in the costs of goods and services which hospitals purchase, improved industry productivity, and changes in technology. Recalibration of the DRG Relative Price Index may also be needed at various times to account for such matters as significant changes in specific diagnostic or treatment technologies, changes in the proportion of costs attributable to wages, significant improvement in the accuracy and completeness of the clinical data on medicare bills, or major changes in clinical coding systems or in DRG definitions.

ADMINISTRATIVE PROCEDURE

Under the Department's proposal, the Secretary would, by September 1 of each year, publish a final notice in the Federal Register establishing the payment amounts for the subsequent fiscal year. For the first year of operation, the proposal would allow a special procedure by which the Department could issue payment amounts by September 1, 1983, without prior opportunity for public comment, and then could modify the payment amounts on the basis of comments received.

EFFECTIVE DATE FOR IMPLEMENTATION

The PPS report indicates that there are two basic choices for an effective date of implementation of the system as it applies to any individual hospital. The first option is for payment to all hospitals to begin on the same date, October 1, 1983. The second option is to phase in the system as hospitals begin their own particular cost reporting periods, on or after the effective date of implementation of the system. The Department prefers to phase in the prospective payment system according to hospitals' own cost reporting periods. All hospitals would begin immediately to be reimbursed under the prospective system during the hospital's first fiscal year after September 1983.

IV. MAJOR ISSUES

The following is a list of major issues that have been identified and are likely to be raised during consideration of the prospective proposal. These are not necessarily areas of disagreement, but more often reflect a need for further clarification and specification by the Department.

1. Payers Covered

Should the proposal cover only medicare as a payer, or be expanded to cover all payers, such as the commercial insurers?

2. Cost Reporting Requirements

To what extent will we continue to require cost reporting by institutions?

Is the data system proposed sufficient to permit us to continue to monitor the mix of services provided to medicare beneficiaries and the cost of those services?

What changes will a hospital need to make in its data collection system? Are these changes likely to result in additional costs for hospitals?

3. Adjustments to DRG

Is there need for an organized process to consider changes in technology and medical practice which could result in changes in the DRG's?

Should a specific inflation factor be included in the statute which would be used to update the prices assigned to DRG's?

4. Gaming the System

How do we prevent a hospital from gaming the system through selective admissions policies? For example, deliberately changing its patient case mix to avoid caring for expensive patients; treatment of patients with multiple short stays?

5. Peer Review

What system will be used to meet our responsibility for oversight of appropriateness and quality of care and to assure the accuracy of the DRG reported?

6. Exceptions and Adjustments

How often are "outliers" likely to occur? How will these costs be reimbursed?

Will the unusual costs incurred by institutions caring for a large population of publicly financed patients be recognized?

Small rural hospitals often have high standby costs that their patient volumes cannot support. How will they be treated under the prospective system?

7. Beneficiary Cost Sharing

There will be pressure from the hospital industry to allow hospitals to bill patients for amounts over and above what medicare pays.

8. Medical Education and Capital Costs

The proposal continues to pass the costs of these hospital areas through with no limit. There is an indication, however, that an attempt will be made in the future to reimburse them on a somewhat different basis. It is not clear what the new system might be, or how soon we should expect it.

9. State Rate Setting

Will the Department continue to allow medicare waivers for State reimbursement systems? What will the criteria be for the waivers?

10. Transition

Will the system be put into place all at once or will there be a gradual transition over time? Is there a need for such a transition?

OPENING STATEMENT OF SENATOR MAX BAUCUS BEFORE THE SENATE FINANCE HEALTH SUBCOMMITTEE

Thank you Mr. Chairman.

For years we have known that there are problems in the Medicare reimbursement system. I'm pleased that today we are discussing some realistic alternatives to the current system.

I also want to commend Secretary Schweiker for his work in this area. His report on prospective reimbursement reflects a great deal of study. He has offered a constructive and helpful proposal for changing the way Medicare reimburses hospitals. I am eager to begin work on it.

However, I have questions about some parts of the administration's plan. I am concerned about how these proposals would affect hospitals in small towns. I'm not sure the DRG methodology would be fair to these hospitals.

I'm also convinced that the incentives created by the DRG methodology make a strong case for an effective network of physician peer review organizations—not their elimination as the administration would prefer.

Nevertheless, the HHS plan is a constructive beginning.

Mr. Chairman, I wish I could say the same for the rest of the HHS budget for Medicare.

For the past three years, the administration has sent us proposals to cut from Medicare. It's kind of like peeling an onion. You strip away layer upon layer year after year—until all you're left with is tears.

The administration seems to have only one answer to rising health care costs: make America's elderly shoulder more of the burden for paying their medical bills.

The administration's plan is flawed. Medicare vouchers would increase the cost of Medicare, without improving medical care. According to the administration's own estimates, vouchers would add at least $50 million to the cost of Medicare.

The administration's proposals to restructure the hospital insurance benefit—Medicare Part A—scraps a reasonably sound hospital insurance policy for the elderly. In return, seniors would get a "catastrophic" scheme that only benefits a few.

Perhaps the most devastating news for the elderly comes from the Administration's proposals to drastically increase what the elderly have to pay for Medicare Part B. We rejected some of these proposals last year. I hope we do so again this year.

All of us understand that there may be problems in the Medicare trust fund in the future. But the responsible way to resolve these problems is to address the root causes for health care cost inflation.

In my view, the solution is not to cut the heart out of Medicare benefits. We need a national commission—just like the Social Security commission—to draft along range plan for medicare. And then to undertake the task of building the political support needed to get it passed.

I don't believe there is any other way to resolve the funding problems that face Medicare.

Senator DURENBERGER. The hearing will come to order with a few brief remarks, then we will hear from an impressive list of individual and panel witnesses.

In my capacity as chairman of this subcommittee, let me set the hearing in the context of the day, not the particular day. I guess it's Groundhog's Day.

Senator DOLE. It's Redskins' Day.

Senator DURENBERGER. Oh, it's Redskins' Day—that kind of hog.

But I read this morning in the Washington Post that some famous political figure who has the responsibility for raising money is still raising money off the social security issue. It just reminds me, having been through one of the most expensive reelection campaigns in the history of this country, that if there's one thing that the people of this country are looking for it's the depoliticalization of the income security system in America, whether it's social security or housing or food stamps or the medicare/medicaid system. And it's in that context that we are today discussing the future of medicare.

The ranking member of this subcommittee and I held hearings last summer on the subject of the future of medicare. The chairman of this committee has been concerned about the future of medicare before the two of us even got here.

So in that kind of a setting, we would hope that those who have a stake in the future of elderly health care are here during this first half of the 98th Congress to do something about elderly health care in America, and by doing something sensible about elderly health care in America to do something sensible to and for the whole health care system.

We have been trying for years to clean up the mess in the health care system that at least in part has been created by the cost-based reimbursement system we have chosen to use for medicare and which has been used by many other third-party payors.

We have spent altogether too much time debating whether or not chiropractors ought to be in, or out, or what kind of nurses ought to be in, or out, or the basic coverage issues that there isn't a person on this committee who is qualified to make judgment on.

We have finally summoned the courage of the Nation, I believe, to change the basic way in which we pay for medicare. Prospective payment is the form that has been chosen. I think it's the shot in the arm that medicare has needed for a long time. I believe it is a positive change. It's good for senior citizens in this country, it's good for physicians, it's good for hospitals, and it's good for taxpayers. And it comes at a time when it is, clearly, desperately needed.

I think the administration and the Secretary of HHS Richard Schweiker, in particular, ought to be complimented for the sensitive, thorough way in which they have approached this issue. There are some of us who weren't sure that he could make the deadline, and he beat the deadline. So the administration is to be complimented for that.

There are details in the administration's proposal that still need to be worked out. It's not a perfect system, as we will undoubtedly find out during the course of today.

The administration has chosen to limit its proposal to only the most important elements of a prospective payment plan, and I think that's a wise choice. It is not to suggest that issues like capital formation, teaching costs, all payor systems are unimportant issues; they are very important issues. Each of them, however, is very complex, and each demands special attention. None of them, in my opinion, has to be addressed in the context of our initial efforts at prospective payment. I think it makes sense to focus on the basic elements of prospective payment now, and to come back to these issues during the course of this year in hearings.

Today's hearing is the first of two that will examine the administration's prospective proposal. We will hear today from the administration, the hospital industry, and the States that have had experience with prospective payment systems.

On February 17 we will hear from other health providers, consumers, insurers, and businesses.

It promises to be an enlightening and I hope lively discussion, and I look forward to hearing from each of you.

Mr. Chairman, do you have a comment?

Senator **Dole**. No.

Senator **Durenberger**. Max?

Senator **Baucus**. Thank you, Mr. Chairman.

For years we have known there are problems in the medicare reimbursement system, and I am pleased that today we are discussing some realistic alternatives to that system.

I also want to commend Secretary Schweiker for his work in the area. His report on prospective reimbursement reflects a great deal of study. He has offered a constructive and helpful proposal for changing the way medicare reimburses hospitals. I am eager to begin work on it.

However, I have questions about some parts of the administration's plan. I am concerned about how these proposals would affect hospitals in small towns. I'm not sure the DRG methodology would be fair to these hospitals.

I'm also convinced that the incentives created by the DRG methodology make a strong case for an effective network of physician peer review organizations—not their elimination, as the administration would prefer.

Nevertheless, the HHS plan is a constructive beginning. Mr. Chairman, I wish I could say the same for the rest of the HHS budget for medicare.

For the past 3 years, the administration has sent us proposals to cut from medicare. It's kind of like peeling an onion. You strip away layer upon layer, year after year, until all you're left with is the tears.

The administration seems to have only one answer to rising health care costs: Make America's elderly shoulder more of the burden for paying their medical bills.

The administration's plan is flawed. Medicare vouchers would increase the cost of medicare without improving medical care. According to the administration's own estimates, vouchers would add at least $50 million to the cost of medicare.

The administration's proposals to restructure the hospital insurance benefit—Part A—scraps a reasonably sound hospital insurance policy for the elderly. In return, seniors would get a "catastrophic" scheme that only benefits a few.

Perhaps the most devastating news for the elderly comes from the administration's proposals to drastically increase what the elderly have to pay for medicare part B. We rejected some of those proposals last year, and I hope we do so again this year.

All of us understand that there may be problems in the medicare trust fund in the future; but the responsible way to resolve these problems, I think, is to address the root causes for health care cost inflation.

In my view, the solution is not to cut the heart out of medicare benefits; rather, we need a national commission, just like the Social Security Commission, to draft a long-range plan for medicare, and then to undertake the task of building the political support needed to get it passed. I don't believe there is any other way to resolve these funding problems, that face medicare.

Nevertheless, Mr. Chairman, in the meantime, I look forward to the hearing today on prospective reimbursement, because I do think that's a constructive start.

Thank you.

Senator **Durenberger**. Thank you very much.

Chairman Dole?

Senator **Dole**. Well, I'll just take a minute.

I want to first congratulate Secretary Schweiker on his promotion to the private sector, and all that comes with that, whatever it is.

You have done an outstanding job, and as a former colleague we certainly appreciated your responsiveness and willingness to discuss all these problems with both sides of the aisle when they arose, and before they arose.

So, we're going to miss you, and we appreciate what you have done very much. I think we'll be in touch with you in another capacity, as we look into other areas of jurisdiction of this committee that you may have an interest in.

Second, I also believe that we can make some progress this year. We have had cooperation from the health industry, whether it's hospitals, physicians, whoever might be involved, and we hope to proceed that way again this year. In fact, I have cited, as an example of willingness to come in and make a contribution to this problem, the hospital industry's efforts last year.

So I am confident and feel positive that we can come together on some program that will help us in the next 10-15-20 years.

I share some of the concerns expressed by Senator Baucus as far as isolated, small rural hospitals are concerned. That will probably be addressed in your statement.

It may be necessary that we go to some commission, though, having been on the Social Security Commission. I think first we should make every effort to resolve the real problem in medicare, the trust fund. In the next few years it is going to be a rather massive problem that we must address.

Again, I congratulate the chairman of this subcommittee and Senator Baucus for their efforts. I just hope we don't get sidetracked, as the chairman has said, on a lot of small issues.

We've got a big, big problem ahead of us in trying to preserve medicare for millions of Americans, and that ought to be the thrust of our hearings. We can look at the budget—we may not agree with the President's budget, but I think we do agree we must have some restraint in the growth of medical care and the costs of medical care. And if somebody has a better idea, then of course we want to examine that closely.

So I am pleased to be a member of this subcommittee, and I look forward to your testimony.

Senator **Durenberger**. Thank you.

Senator Long?

Senator **Long**. No statement.

Senator **Durenberger**. Thank you.

The first witness is Hon. Richard Schweiker.

Dick, welcome.

STATEMENT OF HON. RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES

Secretary **Schweiker**. Thank you.

Mr. Chairman, members of the committee, it is a distinct pleasure to be here today to discuss with you the Department's proposal to reform the hospital reimbursement system under medicare. This plan provides a significant opportunity to achieve our mutual objectives: to encourage hospitals to provide patient care efficiently, to allow medicare to become a prudent buyer of services, and at the same time to assure the quality of patient care.

Mr. Chairman, we hope this initiative will become truly a joint endeavor. Your committee and the full Senate Finance Committee, under Chairman Dole's leadership, have been instrumental in initiating not only the requirement for a prospective payment plan, but in developing significant reimbursement changes that recently were enacted into law. These interim improvements and your directions to us have paved the way for the permanent reforms that we are discussing today.

Fundamental changes are needed in medicare if we are to control the rate of growth in expenditures, protect the financial stability of the Hospital Insurance Trust fund, and preserve the integrity of the program itself. Today, over two-thirds of all medicare expenditures are for inpatient hospital care; therefore, a primary opportunity for these changes is the way we pay hospitals.

Medicare expenditures for hospital care have averaged a 19-percent increase each year between 1979 and 1982. These increases have been especially noticeable over the past year. While we slowed overall inflation to 3.9 percent during 1982, overall hospital costs rose triple, three times faster, or 12.6 percent.

Congress has recognized in the Tax Equity and Fiscal Responsibility Act, TEFRA, that the medicare reimbursement system needed major structural reform to eliminate perverse incentives, promote efficiency, and thereby reverse the inflationary spiral in hospital expenditures. I commend this committee particularly for taking the lead in that respect.

Recognizing the need for fundamental reform this committee initiated the congressional mandate for development of a prospective payment proposal, a system which would establish hospital payment rates in advance of the delivery of care, instead of determining the cost after the care has been provided.

And now, if you would look to your right and my left, I would like to just run through a few charts that I hope will simplify a subject that has some detail and complexity to it.

[Showing of charts.]

Secretary SCHWEIKER. Over on your right, the first chart illustrates one of the points I would like to make, which is that we have a cost-plus reimbursement system now, one that I look at as parallel to what we did in World War II, when we simply went out and bought a lot of things we needed and let everybody add up the price, and passed the bill along.

Unfortunately, when a bill comes through our system now, unless there is malfeasance involved, we end up paying it. And maybe that's right or wrong, but for a prudent buyer, it's very inefficient.

So right now the system lacks an incentive to costs; we pay whatever hospitals spend. There is no reward for the efficient delivery.

As I mentioned a moment ago, our hospital medicare expenditures averaged 19 percent a year for 3 years; the deductible, which is an index of what costs have gone up, has gone up 17.7 percent over the last 3-4 year period; and just this year the costs of hospital care have tripled over the rate of inflation.

So, I think that gives you the background of the problem that we are struggling to work with.

[Change of charts.]

Secretary **Schweiker**. This chart shows the rise in medicare expenditures for hospitals.

I might say, my Department will spend in the 1984 budget $85 billion for health care costs—$85 billion between medicare and medicaid, total cost. We pay 40 percent of all the hospital bills.

[Change of charts.]

Secretary **Schweiker**. These bar graphs show how that particular segment, medicare payment for hospitals, has grown.

The 1984 bar, which is not shown there, is $44.7 billion. So, as you can see, there is a geometric escalation of hospital expenditures for medicare.

[Change of charts.]

Secretary **Schweiker**. The next chart shows that Medicare will pay $38 billion for hospital care in 1983. That will go to $44.7 billion in 1984.

The root of the problem that I would like to point out here is shown by these next figures. If a hospital in one town has a heart attack victim that has a simple heart attack with no complications, no pacemaker, no surgery, we can pay as little as $1,500 to that hospital when they send us the bill. A similar hospital, right down the street, as a matter of fact, could send us a bill for $9,000 for the same kind of heart attack—no complications, no pacemaker, no surgery. And we'll pay it. And unfortunately, we will pay it almost no questions asked.

So in essence we are saying that we pay a 6 to 1 differential on the bills that we receive for this one type of medical treatment for a heart attack.

I will just pull out two other quick illustrations that make the same point: If you are talking about hip replacements, we will pay as little as $2,100 and as high as $8,200 for a hip replacement operation, or a 4 to 1 differential.

Now, again, we are measuring the same thing, the same kind of hip replacement case, either with or without complications. So we are not comparing apples and oranges, we are comparing the same diagnosis, the same remedy, the same technique.

And finally, it's an even worse situation, where you are paying $450 to remove a cataract in one instance, versus $2,800 in another. A 7 to 1 ratio.

I think that shows us that we have a system that we really cannot intelligently use to buy services. And medicare is paying up to 40 percent of the total hospital bills in this country.

[Change of charts.]

Secretary **Schweiker**. We believe that a prospective payment system, first of all, will give hospitals an incentive to control costs, because hospitals will know in advance how much they will be paid for treating that patient.

That will alert them to not overtreat a patient. Also if they figure out ways to operate more efficiently, they can keep a portion of the payment and make a profit on it, which is an incentive that presently isn't in the system.

It provides a management incentive. Right now the hospital administrator is somewhat of a victim. Everybody sends him the bill and he just has to stamp his name on it and go along with it, because he has no rational, logical management method to challenge it.

With this kind of a pricing tool, he will know whether his people are out of line. If he sees they are inefficient, he can go to them and make that very point.

The third advantage I see of this system is, it encourages economic specialization. Right now we have professional specialization, where doctors specialize in their favorite areas; and that's right and proper. But hospitals have no incentive to specialize in what they do best economically, like all other parts of our economy does. Because of the third-party reimbursement system there is no incentive to do that.

I believe that by letting the hospitals know whatever our prepricing judgment is on a procedure, they will have an incentive to specialize in those things that will be productive for them.

We are going to limit payment increases to adjustments for cost of living and an allowance for new technology. So once we set a prospective payment rate for a DRG, it would be adjusted each year by a market basket formula, for some kind of reasonable inflation cost, and also for new technology.

One of the big advantages is that we hope to eliminate a big share of the medicare cost reports. If you talk to hospital administrators, they will tell you they spend a tremendous amount of time in this regard. Because we will be doing away with the cost-reporting system that we now have, they won't have to keep the kinds of records they have had to in the past, and we believe that a high proportion of their present recordkeeping can be eliminated.

[Change of charts.]

Secretary SCHWEIKER. Next I would like to describe how the system works.

We would divide patients into categories based on the diagnoses that they receive when they leave the hospital, which would be the latest diagnosis and the most recent one that reflects their actual condition.

This is not a new system as some people think. It was developed by Yale University and has been evolving for 10 years. We have even run samples of our system. Information on one out of every five cases that goes through our medicare reimbursement system goes into our MEDPAR file, and we actually have a 20-percent sample of medicare cases. So, we do have a good data base, based first on a 10-year study and then on a 1-in-5 sampling technique.

A

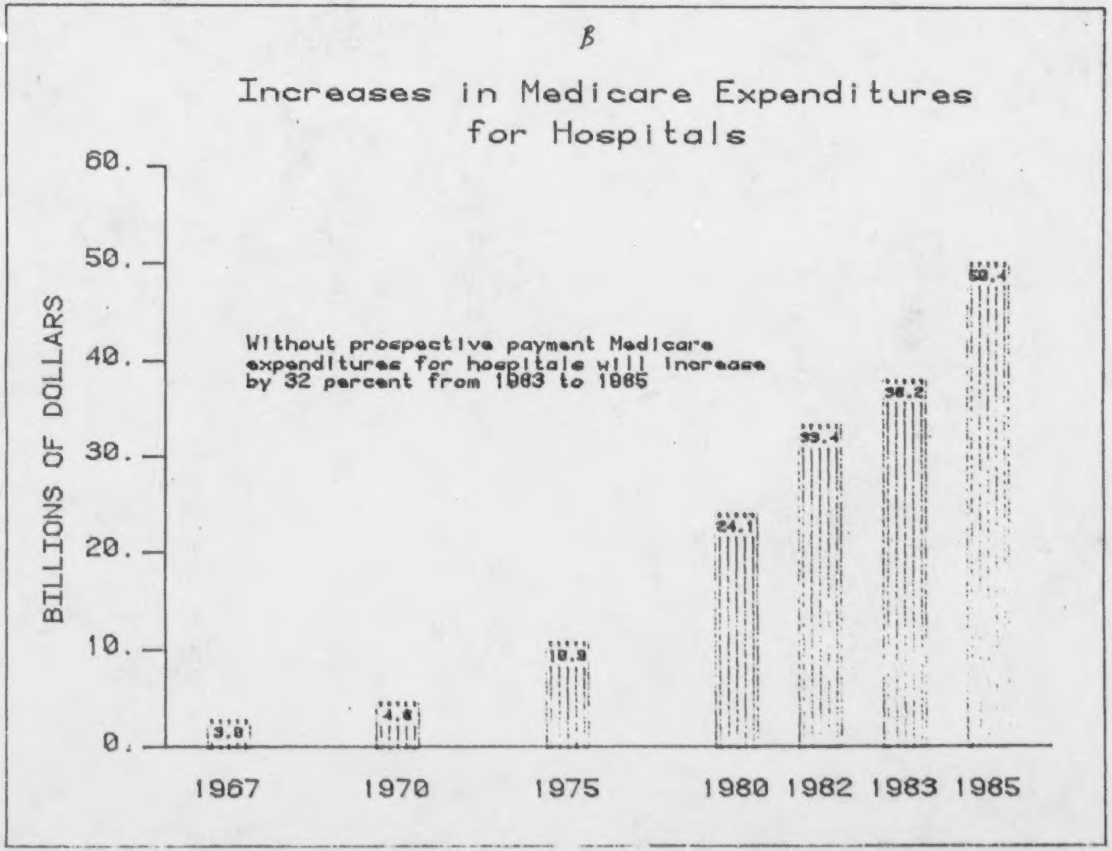
Cost-Based Reimbursement

A "Cost - Plus" Approach

o Hospitals lack incentive to control costs
  - Hospitals are paid whatever they spend

o There is no reward for efficient delivery of care
  - Less expensive hospitals are not rewarded for good performance

o Hospital expenditures show rapid increases
  - Medicare expenditures for hospital services have increased 19.2% per year from 1979-1982
  - The Medicare deductible which measures the average cost of a day of hospital care increased 17.7% per year from 1979 - 1982
  - During 1982 inflation in hospital costs increased three times faster than the overall inflation rate - 12.6% vs. 3.9%



β

Increases in Medicare Expenditures for Hospitals

Without prospective payment Medicare expenditures for hospitals will increase by 32 percent from 1983 to 1985

Medicare as Prudent Buyer

- Medicare will purchase $38 billion of hospital care in 1983

- Medicare's payments for treating a heart attack can average $1500 at one hospital and $9000 at another hospital with no apparent difference in quality
  - Medicare payments for hip replacement can vary from $2100 to $8200
  - Medicare payments for cataract removal can vary from $450 to $2800

Prospective Payment

- Provides hospitals an incentive to control costs
  - Hospitals know how much they will be paid for treating a patient in advance

- Rewards for efficient delivery of care
  - Hospitals that operate efficiently will retain surplus - A management incentive

- Encourages hospitals to do what they do best in certain specialities - Economic specialization

- Limits payment increases
  - Increases are limited to adjustments for cost of living and an allowance for new technology

- Reduces regulatory burden on hospitals
  - Medicare cost report virtually eliminated

Payments to Hospitals

- Patients are categorized into specific groups based on diagnoses
  - diagnosis related groups - DRGs

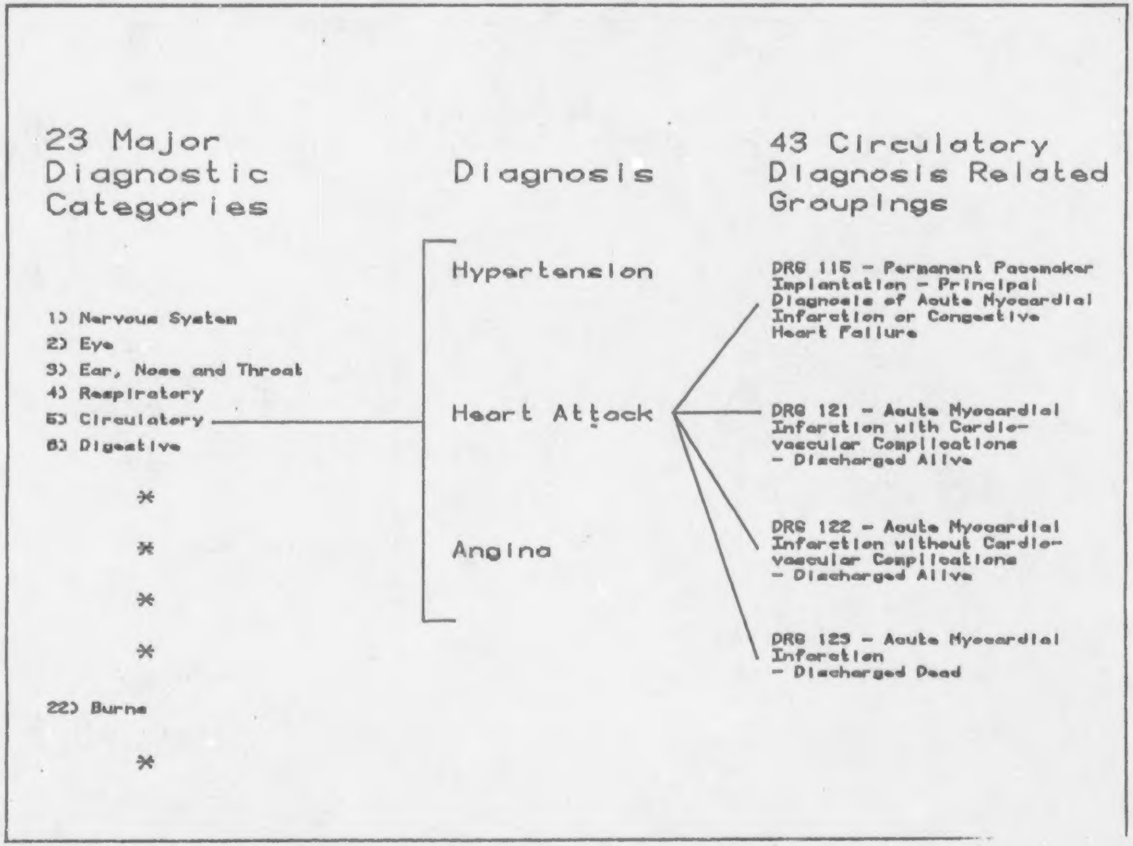
- Refinement of DRGs achieved over 10 years through major HCFA research and demonstration program with Yale University

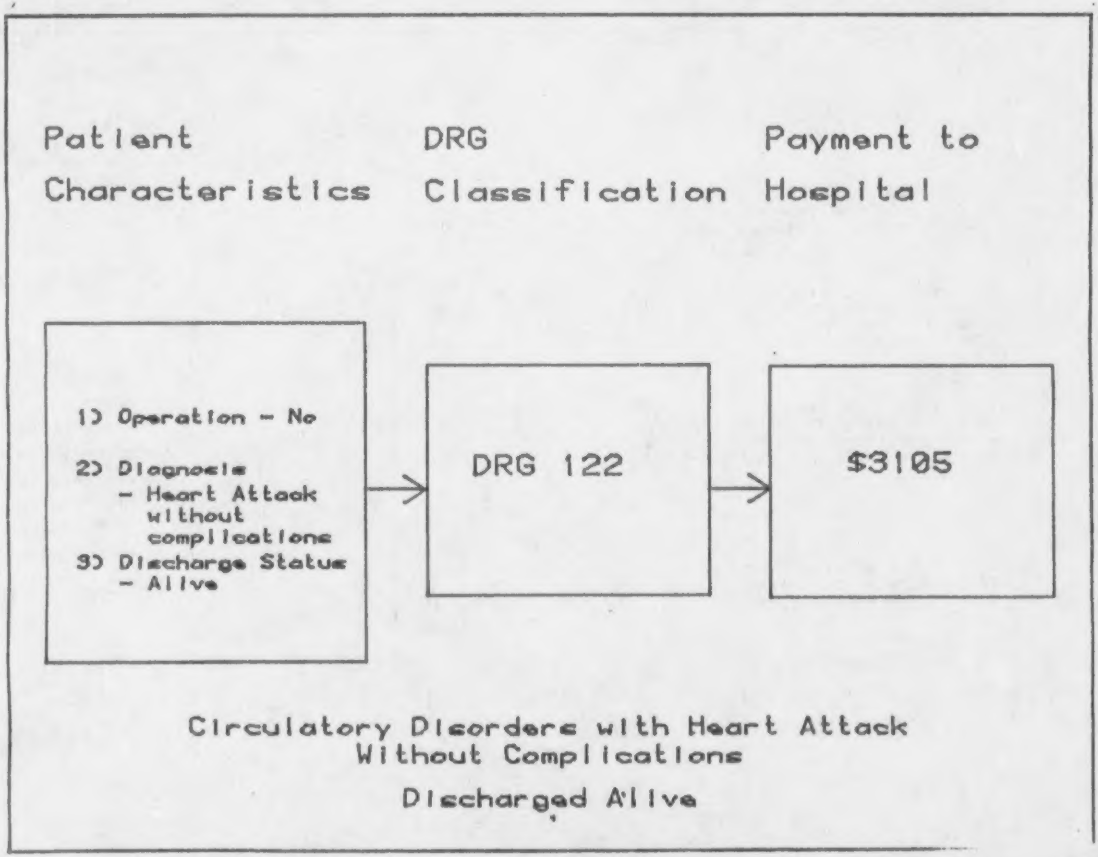
- Payment rates depend on discharge diagnosis plus hospital-specific adjustment formula
  - wage rates in the area
  - teaching costs
  - capital costs

Diagnosis Related Groups

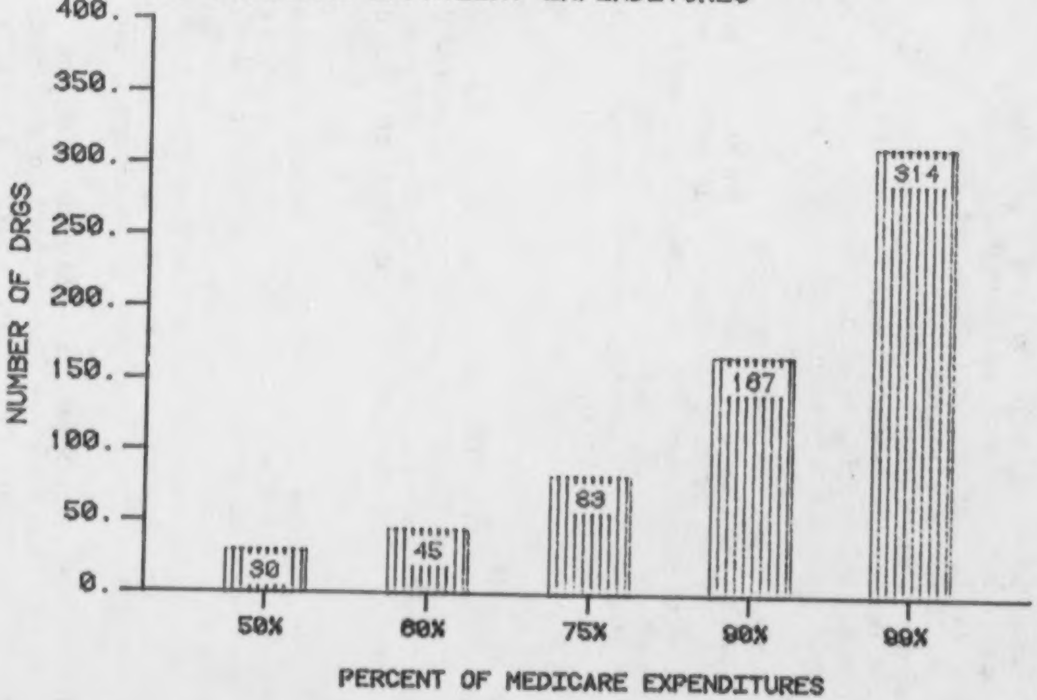
- Patients classified into 467 groups

- Classification based on
  - patient diagnoses
  - patient's age
  - procedure utilized for treatment
  - discharge status


23 Major Diagnostic Categories
1) Nervous System
2) Eye
3) Ear, Nose and Throat
4) Respiratory
5) Circulatory
6) Digestive
*
*
*
*
22) Burns
*
Diagnosis
Hypertension
Heart Attack
Angina
43 Circulatory Diagnosis Related Groupings
DRG 115 - Permanent Pacemaker Implantation - Principal Diagnosis of Acute Myocardial Infarction or Congestive Heart Failure
DRG 121 - Acute Myocardial Infarction with Cardiovascular Complications - Discharged Alive
DRG 122 - Acute Myocardial Infarction without Cardiovascular Complications - Discharged Alive
DRG 123 - Acute Myocardial Infarction - Discharged Dead


Patient Characteristics
DRG Classification
Payment to Hospital
1) Operation - No
2) Diagnosis - Heart Attack without complications
3) Discharge Status - Alive
DRG 122
$3105
Circulatory Disorders with Heart Attack Without Complications
Discharged Alive

NUMBER OF DRGS ACCOUNTING FOR PERCENTAGES
OF MEDICARE INPATIENT EXPENDITURES



(Based on 1979 Medpar Data)

Finally, we are going to adjust the rates, based on area wage differences. We know that wages comprise 60 percent of a hospital's direct costs; indirectly they might account for up to 80 percent of a hospital's costs. So we are going to have a payment price that relates to the standard metropolitan statistical area, so that the rural wage rates, the high urban wage rates, will all be taken into consideration for that area's hospitals.

As Chairman Durenberger mentioned a moment ago, we are going to put teaching costs on a separate track so that we will not impinge directly on teaching hospitals, and they will not be penalized for their extraordinary contributions they make in medical education.

Capital costs will also be paid separately.

Now, I want to say this is something that we are not attempting to solve now. By segregating these costs out now, it makes the system easier to implement. By the same token, we reserve the right to come back and look at a capital cost expenditure, and maybe deal with it at some future time. Because we have segregated it we will be able to get a handle on it in a more readily identifiable way. So we are not proposing anything now, except we will keep tabs on it.

[Change of charts.]

Secretary SCHWEIKER. The next chart shows how under our system there are roughly 467 diagnosis-related groups and classifications are based on the patient's specific illness, the patient's age, the procedure or surgery used for treatment, and his discharge status.

[Change of charts.]

Secretary SCHWEIKER. The next chart breaks diagnoses down very specifically: There are 23 major diagnostic categories. They are rather obvious categories: The nervous system; the eye, ear, nose and throat; respiratory; circulatory; and so on, down the list.

Under each major category are two subbreakdowns. Here I am taking the one in red, circulatory, through to the end product; the three sub-categories under that are: hypertension, heart attack, and angina.

Let's follow the heart attack one through to the next division and you will find that there are four kinds of heart attacks that we would reimburse for, from the simple one with no surgery, no complications, et cetera, to a more complicated one that would have a pacemaker and would have complications, et cetera. And each of those four DRG's would be paid at a different rate.

[Change of charts.]

Secretary SCHWEIKER. Next, here is a specific one: DRG No. 122. Again, this happens to be a heart attack. There was no operation required. The diagnosis was a "heart attack without complication." The patient lived. And the price for this would be, as an example, roughly $3,105.

And that would be the way the system would work, basically.

[Change of charts.]

Secretary SCHWEIKER. Finally, lest some people think it would be too complicated, let me just say that even though we are talking 400 and some diagnoses, actually the bulk of the medicare diagnoses fall into some very, very few groups.

If you look at this chart, 50 percent of the medicare expenditures are actually for only 30 of these specific diagnoses. Sixty percent of all the patients would be covered by 45, and three-quarters of your patients would only have 83 diagnoses. So three-quarters of the system would operate on 83 basic diagnoses.

Now I would like to just finish reading my brief opening statement, then I will be glad to answer your questions.

The changes in TEFRA that this committee developed represent an important interim improvement in the current system. However, even they do not provide sufficient incentive for hospitals to keep their costs below the limit; thus, TEFRA does not alter the fundamental nature of retrospective cost-based reimbursement, nor does it eliminate the incentives which reward increased spending by hospitals.

The provisions in TEFRA have laid the groundwork for this major reform—a viable prospective payment system—in several ways:

They provide an initial incentive for efficient hospital management, as well as penalties for inefficiency, and thus establish the concept that the payment system should reward the efficient and penalize the inefficient;

They are applied on a per-case basis, which is a good starting point, rather than paying hospitals for each day of care.

Each hospital's limit is adjusted to reflect the different kinds of patients it usually treats, recognizing for the first time the need for a case-mix adjustment in a hospital payment system.

So we already have in place a case-mix analysis of the hospitals in question, which will be very fundamentally useful in our system.

In recognition of the interim nature of TEFRA, this committee included a requirement that the Department develop a prospective payment proposal, and on December 28 of last year I presented that report to the Congress.

You all have a copy of this blue report—which we did send up, I might say, on time, in accordance with your direction.

The Department's prospective payment system has five primary elements:

Hospitals will be paid on the basis of output. We propose that hospital payment be set on a per-discharge basis, based on the specific diagnosis and characteristics of the patient.

Hospitals in a geographical area will be paid the same rate for the same service—that's the wage-rate factor—thus, we can eliminate the situation where payments for hip replacements in the same geographic area may vary from that $2,100 to $8,400 cost that I showed you earlier.

Payment rates cover all operating costs. Initially capital and medical education costs would not be included in the prospective rate, but would be treated as they are under current law.

Special provisions would be made for cases with extraordinary lengths of stay—what we call "outliers"—so that no small hospital or even the large hospital with a lot of extraordinary cases would have these abnormal statistics work against them.

The system covers short-term general hospitals. Because of the special populations served by long-term care hospitals, psychiatric and children's hospitals, we would not include them in the prospective payment system at this time. We would be looking at the possibility of including them in the future, but we feel it's premature to include them now. They would be paid for services as under the current law. And special provisions will be made for sole community providers to assure beneficiary access to care.

I think it is very important to say that, even though we expect specialization and hope where there is a lot of competition this will occur, there will be sole providers in certain isolated areas which probably cannot meet the competition that we see in the system.

So we will have a procedure for exceptions and provisions to assure that people in rural areas and isolated areas will receive access to quality of care. That's a very fundamental tenet of our system. If we didn't have that provision, frankly I wouldn't be for it, and it's something that basically is provided in the system because we realize that this may be a factor, and we can't expect competition to exist where it doesn't occur. So we are not mandating that it does.

There are some specific issues raised in discussing prospective payment that I believe need to be addressed:

First of all, medical education poses special problems. In addition to patient care, teaching hospitals provide training for 70,000 residents. This education function, which we as a society expect them to perform, adds to their total cost.

One approach would be to use the same method to adjust for educational costs, under prospective payment, as is currently used in implementing section 101 of TEFRA. Direct costs associated with medical education, specifically resident and faculty salaries, are given a complete passthrough and paid to the hospital. A formula is used to calculate and pay for indirect costs of medical education—all of the unmeasurable costs associated with teaching.

The Department recognizes that this approach requires further scrutiny. Two years ago we commissioned a major study to examine the financing of graduate medical education. Results from this study are not expected for another year. In the meantime, we are pursuing other research in this area, and we anticipate that these studies will allow the Department to refine the methodology later. That's why we are basically continuing the present system.

Payment for capital-related cost: Capital costs include depreciation, interest, rent, leasing, and similar expenses. These costs represent an average of 6 percent of hospital expenditures.

We plan no change in the way we pay for these costs at present. Because of the variance in existing capital costs, we initially plan to exclude these expenses from the prospective payment rate and reimburse for capital on a cost basis.

In the long run, however, the Department wants to develop a better method which would pay capital costs on a prospective basis.

Quality of care: The prospective payment system will enable us to maintain our commitment to high quality hospital care. While quality of care is difficult to define precisely, most indications are that in hospitals it has not deteriorated in States which have operated prospective reimbursement systems for some years.

In fact, our prospective payment proposal may enhance the quality of care provided to medicare beneficiaries. This system has the advantage of encouraging hospitals to specialize in those types of cases which they can treat efficiently and effectively.

Most studies have shown that as other hospitals specialize in providing services, the quality of care in fact improves.

Reduction of reporting burdens: One of the elements of prospective reimbursement about which we are most excited is the reduction of the paperwork and cost-reporting burden on the hospital. Our preliminary estimates indicate that at least 25 percent of the reporting schedules will be eliminated, with a cost-funding reduction approaching about 5 million burden hours per year.

In conclusion, Mr. Chairman, I believe that prospective payment is a necessary step in our effort to establish appropriate economic incentives in the medicare program, and to establish the Federal Government as a prudent buyer of services.

We look forward to working with you on this important initiative.

Thank you.

[The prepared statement of Secretary Schweiker follows:]

STATEMENT OF

RICHARD S. SCHWEIKER
SECRETARY OF HEALTH AND HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, IT IS A DISTINCT PLEASURE TO BE HERE TODAY TO DISCUSS WITH YOU THE DEPARTMENT'S PROPOSAL TO REFORM THE HOSPITAL REIMBURSEMENT SYSTEM UNDER MEDICARE. THIS PLAN PROVIDES A SIGNIFICANT OPPORTUNITY TO ACHIEVE OUR MUTUAL OBJECTIVES: TO ENCOURAGE HOSPITALS TO PROVIDE PATIENT CARE EFFICIENTLY; TO ALLOW MEDICARE TO BECOME A PRUDENT BUYER OF SERVICES; AND AT THE SAME TIME TO ASSURE THE QUALITY OF PATIENT CARE.

MR. CHAIRMAN, WE HOPE THIS INITIATIVE WILL BECOME TRULY A JOINT ENDEAVOR. YOUR COMMITTEE AND THE FULL SENATE FINANCE COMMITTEE, UNDER CHAIRMAN DOLE'S LEADERSHIP, HAVE BEEN INSTRUMENTAL IN INITIATING NOT ONLY THE REQUIREMENT FOR A PROSPECTIVE PAYMENT PLAN, BUT IN DEVELOPING SIGNIFICANT REIMBURSEMENT CHANGES RECENTLY ENACTED INTO LAW. THESE INTERIM IMPROVEMENTS AND YOUR DIRECTIONS TO US HAVE PAVED THE WAY FOR THE PERMANENT REFORMS WE ARE DISCUSSING TODAY.

BACKGROUND

FUNDAMENTAL CHANGES ARE NEEDED IN MEDICARE IF WE ARE TO CONTROL THE RATE OF GROWTH IN EXPENDITURES, PROTECT THE FINANCIAL STABILITY OF THE HOSPITAL INSURANCE TRUST FUND AND PRESERVE THE

INTEGRITY OF THE PROGRAM ITSELF. TODAY, OVER TWO-THIRDS OF ALL MEDICARE EXPENDITURES ARE FOR INPATIENT HOSPITAL CARE; THEREFORE A PRIMARY OPPORTUNITY FOR THESE CHANGES IS THE WAY WE PAY HOSPITALS.

MEDICARE EXPENDITURES FOR HOSPITAL CARE HAVE AVERAGED A 19 PERCENT INCREASE EACH YEAR BETWEEN 1979 AND 1982. THESE INCREASES HAVE BEEN ESPECIALLY NOTICEABLE OVER THE PAST YEAR. WHILE WE SLOWED OVERALL INFLATION TO 3.9 PERCENT DURING 1982, OVERALL HOSPITAL COSTS ROSE OVER THREE TIMES FASTER -- OVER 12.6 PERCENT.

A BASIC REASON FOR PAST RAPID COST INCREASES IS THE WAY WE PAID HOSPITALS. THE TRADITIONAL MEDICARE RETROSPECTIVE COST-BASED SYSTEM OF REIMBURSEMENT PROVIDED INCENTIVES FOR HOSPITALS TO SPEND -- NOT TO CONSTRAIN COSTS. IN THE PAST, MEDICARE REWARDED INCREASED EXPENDITURES -- NOT PRUDENT MANAGEMENT.

CONGRESS HAS RECOGNIZED IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT (TEFRA) THAT THE MEDICARE REIMBURSEMENT SYSTEM NEEDED MAJOR STRUCTURAL REFORM TO ELIMINATE THESE "PERVERSE" INCENTIVES, PROMOTE EFFICIENCY, AND THEREBY REVERSE THE INFLATIONARY SPIRAL IN HOSPITAL EXPENDITURES.

RECOGNIZING THE NEED FOR FUNDAMENTAL REFORM, THIS COMMITTEE INITIATED THE CONGRESSIONAL MANDATE FOR DEVELOPMENT OF A PROSPECTIVE PAYMENT PROPOSAL, A SYSTEM WHICH WOULD ESTABLISH HOSPITAL PAYMENT RATES IN ADVANCE OF THE DELIVERY OF CARE, INSTEAD OF DETERMINING THE COST AFTER THE CARE HAS BEEN PROVIDED.

OBJECTIVES OF A PROSPECTIVE PAYMENT PLAN

A NEW METHOD FOR PAYING HOSPITALS MUST BE BASED ON A SET OF SOUND PRINCIPLES. IN ADDITION TO REMOVING THE INHERENT DISINCENTIVES OF COST-BASED REIMBURSEMENT, A NEW SYSTEM SHOULD:

- ESTABLISH THE FEDERAL GOVERNMENT AS A PRUDENT BUYER OF SERVICES AND ENHANCE OUR ABILITY TO PREDICT FEDERAL EXPENDITURES;

- ENSURE THAT HOSPITALS CAN PREDICT THEIR MEDICARE REVENUES;

- PROVIDE INCENTIVES FOR HOSPITAL MANAGEMENT FLEXIBILITY, INNOVATION, PLANNING, CONTROL AND EFFICIENT USE OF HOSPITAL RESOURCES;

- BE EASY TO UNDERSTAND, SIMPLE TO ADMINISTER AND BE ONE WHICH CAN BE IMPLEMENTED QUICKLY;

- REDUCE THE COST REPORTING BURDEN ON HOSPITALS;

- LIMIT BENEFICIARY LIABILITY TO COINSURANCE AND DEDUCTIBLES ESTABLISHED BY LAW AND ASSURE BENEFICIARY ACCESS TO APPROPRIATE QUALITY CARE; AND

- ASSURE THAT MEDICARE EXPENDITURES FOR INPATIENT HOSPITAL SERVICES ARE NO GREATER THAN THE AMOUNT THAT WOULD BE SPENT IF THE PRESENT SYSTEM OF REIMBURSEMENT, WITH TEFRA LIMITATIONS, WERE CONTINUED.

THESE OBJECTIVES PROVIDE THE BASIC FRAMEWORK WITHIN WHICH WE ANALYZED THE CURRENT SYSTEM AND DEVELOPED A PLAN FOR THE FUTURE.

TEFRA COST PROVISIONS

BEFORE DISCUSSING OUR PROSPECTIVE PAYMENT PROPOSAL IN DETAIL, IT IS IMPORTANT TO NOTE THE INTERIM CHANGES IN REIMBURSEMENT PUT INTO PLACE UNDER SECTION 101 OF P.L. 97-248, THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA).

UNTIL ENACTMENT OF SECTION 101, SIGNIFICANT INCENTIVES WITHIN THE MEDICARE REIMBURSEMENT SYSTEM FOR COST CONSTRAINT WERE NOT APPLIED.

THE NEW AUTHORITY IN SECTION 101 OF TEFRA EXTENDS THE SCOPE OF THE LIMITS ON ALLOWABLE COSTS PAID TO HOSPITALS FOR THE CARE OF MEDICARE PATIENTS. THE NEW COST LIMITS APPLY TO TOTAL MEDICARE INPATIENT OPERATING COSTS. IN ESTABLISHING THE LIMITS, EACH HOSPITAL'S COST IS ADJUSTED USING A CASE-MIX INDEX BASED ON DIAGNOSIS RELATED GROUPS (DRGS). PREVIOUS LIMITS APPLIED ONLY TO ROUTINE HOSPITAL COSTS AND DID NOT INCLUDE THE COST OF ANCILLARY SERVICES, WHICH ACCOUNT FOR ABOUT HALF OF TODAY'S HOSPITAL BILLS.

IN ADDITION TO THE NEW COST LIMITS, THE TEFRA PROVISIONS ESTABLISH TARGET RATES WHICH LIMIT THE AMOUNT BY WHICH A HOSPITAL'S REIMBURSEMENT CAN BE INCREASED EACH YEAR. IN THE FIRST YEAR, HOSPITALS OVER THE TARGET RATE LOSE 75 PERCENT OF THE COSTS OVER THE TARGET. HOSPITALS SPENDING UNDER THE TARGET RATE WILL BE ALLOWED TO KEEP ONE-HALF OF THE SAVINGS.

THE CHANGES IN TEFRA REPRESENT IMPORTANT INTERIM IMPROVEMENTS IN THE CURRENT SYSTEM. HOWEVER, EVEN THEY DO NOT PROVIDE SUFFICIENT INCENTIVE FOR HOSPITALS TO KEEP THEIR COSTS BELOW THE LIMIT. THUS, TEFRA DOES NOT ALTER THE FUNDAMENTAL NATURE OF RETROSPECTIVE COST-BASED REIMBURSEMENT -- NOR DOES IT ELIMINATE THE INCENTIVES WHICH REWARD INCREASED SPENDING BY HOSPITALS.

THE PROVISIONS IN TEFRA HAVE LAID THE GROUNDWORK FOR MAJOR REFORM -- A VIABLE PROSPECTIVE PAYMENT SYSTEM -- IN SEVERAL WAYS:

- THEY PROVIDE AN INITIAL INCENTIVE FOR EFFICIENT HOSPITAL MANAGEMENT, AS WELL AS PENALTIES FOR INEFFICIENCY, AND THUS ESTABLISH THE CONCEPT THAT THE PAYMENT SYSTEM SHOULD REWARD THE EFFICIENT AND PENALIZE THE INEFFICIENT;

- THEY ARE APPLIED ON A PER CASE BASIS -- RATHER THAN PAYING HOSPITALS FOR EACH DAY OF CARE THEY PROVIDE;

- EACH HOSPITAL'S LIMIT IS ADJUSTED TO REFLECT THE DIFFERENT KINDS OF PATIENTS IT USUALLY TREATS, RECOGNIZING FOR THE FIRST TIME THE NEED FOR SUCH AN CASE MIX ADJUSTMENT IN A HOSPITAL PAYMENT SYSTEM.

IN RECOGNITION OF THE INTERIM NATURE OF THE TEFRA PROVISIONS, THIS COMMITTEE INCLUDED A REQUIREMENT THAT THE DEPARTMENT DEVELOP A PROSPECTIVE PAYMENT PROPOSAL. ON DECEMBER 28, 1982, I PRESENTED THAT REPORT TO THE CONGRESS.

THE REPORT WAS THE RESULT OF A HIGH DEGREE OF EFFORT AND ANALYSIS WITHIN THE DEPARTMENT. DURING THIS PROCESS, WE EXAMINED NUMEROUS METHODOLOGIES WHICH COULD BE USED AS THE BASIS FOR A PROSPECTIVE PAYMENT SYSTEM. WE DREW UPON THE KNOWLEDGE OBTAINED

FROM EXTENSIVE RESEARCH ON HOSPITAL REIMBURSEMENT AND NUMEROUS STATE DEMONSTRATIONS OF PROSPECTIVE PAYMENT. SOME OF THE OPTIONS WERE MORE SUCCESSFUL AT ACHIEVING THE OBJECTIVES I OUTLINED EARLIER THAN OTHERS. THESE VARIOUS ALTERNATIVES ARE DISCUSSED IN DETAIL IN THE REPORT TRANSMITTED AT THE END OF DECEMBER.

THE DEPARTMENT'S PROSPECTIVE PAYMENT PROPOSAL

THE DEPARTMENT'S PROPOSED PROSPECTIVE PAYMENT SYSTEM HAS FIVE PRIMARY ELEMENTS:

O HOSPITALS WILL BE PAID ON THE BASIS OF OUTPUT: WE PROPOSE THAT HOSPITAL PAYMENT BE SET ON A PER DISCHARGE BASIS, BASED ON THE SPECIFIC DIAGNOSIS AND CHARACTERISTICS OF THE PATIENT;

O HOSPITALS IN A GEOGRAPHIC AREA WILL BE PAID THE SAME RATE FOR THE SAME SERVICE: AT PRESENT, FOR EXAMPLE, PAYMENTS FOR HIP REPLACEMENTS CAN VARY FROM $2100 TO $8400, WITH NO DIFFERENCE IN QUALITY. PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM WILL RECOGNIZE EXISTING DIFFERENCES IN AREA WAGE COSTS, BUT ALL HOSPITALS IN AN AREA WILL RECEIVE THE SAME PAYMENT FOR THE SAME SERVICE;

- PAYMENT RATES COVER ALL OPERATING COSTS: INITIALLY, CAPITAL AND MEDICAL EDUCATION COSTS WOULD NOT BE INCLUDED IN THE PROSPECTIVE RATE, BUT WOULD BE PAID SEPARATELY;
- SPECIAL PROVISIONS WILL BE MADE FOR CASES WITH EXTRAORDINARY LENGTHS OF STAY;
- THE SYSTEM COVERS SHORT-TERM GENERAL HOSPITALS. BECAUSE OF THE SPECIAL POPULATIONS SERVED BY LONG TERM CARE HOSPITALS, PSYCHIATRIC AND CHILDREN'S HOSPITALS, WE WOULD NOT INCLUDE THEM IN THE PROSPECTIVE PAYMENT SYSTEM AT THIS TIME. THEY WOULD BE PAID FOR SERVICES AS UNDER CURRENT LAW. SPECIAL PROVISION WILL BE MADE FOR SOLE COMMUNITY PROVIDERS TO ASSURE BENEFICIARIES ACCESS TO CARE. THESE ELEMENTS WILL BE REVIEWED CAREFULLY IN THE DEVELOPMENT OF A DRAFT BILL BY THE ADMINISTRATION.

PROSPECTIVE PAYMENT ISSUES

AT THIS POINT, LET ME DISCUSS THE SYSTEM WE PROPOSE -- AND SOME OF MAJOR ISSUES WHICH HAVE BEEN RAISED -- IN GREATER DETAIL.

PAYMENT PER DISCHARGE: WE PROPOSE TO SET A PAYMENT RATE FOR EACH SPECIFIC TYPE OF DISCHARGE. SINCE PATIENTS HAVE DIFFERENT DIAGNOSES AND TREATMENTS, ARE OF DIFFERENT AGES AND DIFFER IN OTHER WAYS, IT IS IMPORTANT FOR A PAYMENT SYSTEM TO EXPLICTLY REFLECT THESE DIFFERENCES.

TO DO SO, WE MUST CLASSIFY AND CATEGORIZE PATIENTS ON A PER DISCHARGE BASIS. THE DEPARTMENT PROPOSES TO CLASSIFY DISCHARGES USING DIAGNOSIS RELATED GROUPS, OR DRGS FOR THIS PURPOSE. THIS CLASSIFICATION SYSTEM WAS ORIGINALLY DEVELOPED AT YALE UNIVERSITY IN THE EARLY 1970S AND HAS BEEN EXTENSIVELY TESTED AND USED IN NEW JERSEY, MARYLAND AND OTHER STATES -- AND TO ADJUST FOR CASE MIX UNDER TEFRA.

THE SYSTEM INCLUDES 467 SEPARATE DRGS, WHICH WERE DEVELOPED BY A PANEL OF PHYSICIANS. DIAGNOSES WERE INITIALLY ALLOCATED TO 23 MAJOR DIAGNOSTIC CATEGORIES BASED ON THE BODY SYSTEM AFFECTED.

EACH CATEGORY WAS FURTHER SUBDIVIDED ACCORDING TO:

O SPECIFIC PRINCIPAL DIAGNOSIS;

O TYPE OF SURGERY;

O COMPLICATIONS;

- OTHER MEDICAL PROBLEMS; AND

- PATIENT AGE.

A NATIONALLY REPRESENTATIVE SAMPLE OF 1.4 MILLION PATIENT DISCHARGE RECORDS AT 325 HOSPITALS WAS USED TO ASSURE THAT CLINICALLY RELATED DIAGNOSES UTILIZED SIMILAR RESOURCES AND COULD THUS BE EXPECTED TO INCUR SIMILAR COSTS.

THE DRGS ARE A METHOD FOR CLASSIFYING PATIENTS IN ORDER TO REFLECT DIFFERENCES IN THE COST OF TREATMENT. THE DEPARTMENT HAS CONCLUDED THAT THE DRG SYSTEM IS THE ONLY CURRENTLY-AVAILABLE METHODOLOGY WHICH CAN BE EASILY USED FOR PROSPECTIVE PAYMENT UNDER MEDICARE. COMPARED TO DRG, THE DEPARTMENT BELIEVES THAT OTHER CASE-MIX MEASURES NOW UNDER DEVELOPMENT ARE EITHER:

- EXPENSIVE TO IMPLEMENT;

- RELY ON CLINICAL JUDGMENT AND ARE THEREFORE SUBJECT TO "GAMING"; OR

- DO NOT COVER ALL MEDICARE CASES.

THE MAJOR ADVANTAGES OF THE DRGS ARE THAT THEY COVER THE ENTIRE PATIENT POPULATION, CONFORM TO THE ACTUAL DELIVERY OF INPATIENT CARE AND GROUP CASES TOGETHER WHICH ARE SIMILAR CLINICALLY AND IN USE OF RESOURCES.

PAYMENT RATES: UNDER THE PROSPECTIVE PAYMENT SYSTEM, RATES WILL BE SET FOR EACH OF THE 467 DIFFERENT DRGS AND HOSPITALS WILL BE PAID BASED UPON THE DRG OF EACH PATIENT. MORE COMPLEX CASES, SUCH AS KIDNEY TRANSPLANTS, WILL RECEIVE MUCH HIGHER PAYMENTS THAN SIMPLER CASES LIKE HERNIA REPAIR. CASES WITH COMPLICATIONS WILL RECEIVE HIGHER PAYMENTS THAN CASES WITHOUT COMPLICATIONS.

SPECIFICALLY, THE PAYMENT RATES WOULD BE SET IN THE FOLLOWING MANNER:

1. USING DATA FROM THE MEDICARE COST REPORTS AND A SAMPLE OF MEDICARE PATIENT RECORDS, WE WILL DETERMINE THE RELATIVE COST OF EACH DRG;

2. THE NATIONAL AVERAGE MEDICARE COST PER DISCHARGE WOULD BE DETERMINED FROM THE MEDICARE COST REPORTS;

3. THE TWO ELEMENTS OF INFORMATION ARE COMBINED TO CREATE A PRICE FOR EACH OF THE 467 DRGS;

4. A LOCALIZED PAYMENT RATE WILL BE CREATED BY ADJUSTING THE NATIONAL STANDARD DRG PRICES FOR LOCAL VARIATIONS IN LABOR-RELATED COSTS BY APPLYING A WAGE INDEX. THIS PROVIDES HOSPITAL DRG PRICE SCHEDULES FOR EACH STANDARD METROPOLITAN STATISTICAL AREA (SMSA) AND EACH NON-SMSA PART OF A STATE.

TREATMENT OF MEDICAL EDUCATION: MEDICAL EDUCATION POSES SPECIAL PROBLEMS. IN ADDITION TO PATIENT CARE, TEACHING HOSPITALS PROVIDE TRAINING FOR 70,000 RESIDENTS. THIS EDUCATIONAL FUNCTION, WHICH WE AS A SOCIETY EXPECT THEM TO PERFORM, ADDS TO THEIR TOTAL COSTS.

ONE APPROACH WOULD BE TO USE THE SAME METHOD TO ADJUST FOR EDUCATIONAL COSTS UNDER PROSPECTIVE PAYMENT AS IS CURRENTLY USED IN IMPLEMENTING SECTION 101 OF TEFRA. DIRECT COSTS ASSOCIATED WITH MEDICAL EDUCATION - SPECIFICALLY, RESIDENT AND FACULTY SALARIES - ARE GIVEN A COMPLETE PASS THROUGH AND PAID TO THE HOSPITAL. A FORMULA IS USED TO CALCULATE AND PAY FOR INDIRECT COSTS OF MEDICAL EDUCATION -- ALL OF THE UNMEASURABLE COSTS ASSOCIATED WITH TEACHING. THE FORMULA USED IN TEFRA ADJUSTS HOSPITAL PAYMENTS BASED ON THE RATIO OF INTERNS AND RESIDENTS PER BED. THUS, LARGE TEACHING HOSPITALS RECEIVE HIGHER PAYMENTS TO REFLECT THEIR INDIRECT COSTS THAN DO HOSPITALS WITH SMALL RESIDENCY PROGRAMS -- OR WITH NO TEACHING PROGRAM AT ALL.

THE DEPARTMENT RECOGNIZES THAT THIS APPROACH REQUIRES FURTHER SCRUTINY. TWO YEARS AGO, WE COMMISSIONED A MAJOR STUDY TO EXAMINE THE FINANCING OF GRADUATE MEDICAL EDUCATION. RESULTS FROM THIS STUDY ARE NOT EXPECTED FOR OVER ANOTHER YEAR. IN THE MEANTIME, WE ARE PURSUING OTHER RESEARCH IN THIS AREA AND WE ANTICIPATE THAT THESE STUDIES WILL ALLOW THE DEPARTMENT TO REFINE THE METHODOLOGY LATER.

PAYMENT FOR CAPITAL-RELATED COST: CAPITAL-COSTS INCLUDE DEPRECIATION, INTEREST, RENT, LEASING AND SIMILAR EXPENSES. THESE COSTS REPRESENT AN AVERAGE OF SIX PERCENT OF HOSPITAL EXPENDITURES. HOWEVER, THIS PERCENTAGE VARIES SIGNIFICANTLY - AMONG HOSPITALS DEPENDING ON HOW RECENTLY THE HOSPITAL MADE A MAJOR CAPITAL PURCHASE, INTEREST RATES AT THE TIME THE HOSPITAL BORROWED MONEY AND OTHER FACTORS.

WE PLAN NO CHANGE IN THE WAY WE PAY FOR THESE COSTS. BECAUSE OF THE VARIANCE IN EXISTING CAPITAL COSTS, WE INITIALLY PLAN TO EXCLUDE THESE EXPENSES FROM THE PROSPECTIVE PAYMENT RATE AND REIMBURSE FOR CAPITAL ON A COST BASIS. IN THE LONG RUN, HOWEVER, THE DEPARTMENT WANTS TO DEVELOP A BETTER METHOD WHICH WOULD PAY CAPITAL COSTS ON A PROSPECTIVE BASIS. A NUMBER OF RESEARCH PROJECTS HAVE RECENTLY BEEN INITIATED WHICH EXAMINE SUCH QUESTIONS AS: HOW TO PHASE IN A NEW SYSTEM; HOW TO SET PAYMENT RATES; AND HOW TO RECOGNIZE DIFFERENT CAPITAL NEEDS IN DIFFERENT TYPES OF HOSPITALS.

QUALITY OF CARE: THE PROSPECTIVE PAYMENT SYSTEM WILL ENABLE US TO MAINTAIN OUR COMMITMENT TO HIGH QUALITY HOSPITAL CARE. WHILE QUALITY OF CARE IS DIFFICULT TO DEFINE PRECISELY, MOST INDICATIONS ARE THAT IN HOSPITALS IT HAS NOT DETERIORATED IN STATES WHICH HAVE OPERATED PROSPECTIVE REIMBURSEMENT SYSTEMS FOR MANY YEARS.

THE DEPARTMENT HAS SPONSORED A MAJOR EVALUATION OF STATE PROSPECTIVE PAYMENT SYSTEMS, WHICH EXAMINED THE PROVISION OF ANCILLARY SERVICES, CHANGES IN THE SCOPE OF SERVICES, READMISSION RATES AND OTHER MEASURE OF QUALITY. THESE STUDIES SHOW NO DETERIORATION IN QUALITY IN STATES WITH PROSPECTIVE PAYMENT SYSTEMS.

IN FACT, OUR PROSPECTIVE PAYMENT PROPOSAL MAY ENHANCE THE QUALITY OF CARE PROVIDED TO MEDICARE BENEFICIARIES. THIS SYSTEM HAS THE ADVANTAGE OF ENCOURAGING HOSPITALS TO SPECIALIZE IN THOSE TYPES OF CASES WHICH THEY CAN TREAT EFFICIENTLY AND EFFECTIVELY. MOST STUDIES HAVE SHOWN THAT, AS HOSPITALS SPECIALIZE IN PROVIDING SERVICES, THE QUALITY OF CARE IMPROVES. THIS IS BECAUSE SOME PROCEDURES REQUIRE A HIGH VOLUME OF CASES TO MAINTAIN PROFICIENCY IN TREATMENT. THE STUDIES INDICATE THAT, WHEN THESE SERVICES ARE PROVIDED IN HOSPITALS WITH LOW VOLUME, QUALITY OF CARE SUFFERS. IN ADDITION, CERTAIN UNNECESSARY

SERVICES, SOME OF WHICH WOULD NOT IMPROVE PATIENT HEALTH, MIGHT BE ELIMINATED AS HOSPITALS AND PHYISICIANS HAVE STRONG INCENTIVES TO PROVIDE CARE MORE EFFICIENTLY.

CONCLUSION

IN CONCLUSION, MR. CHAIRMAN, I BELIEVE THAT PROSPECTIVE PAYMENT IS A NECESSARY STEP IN OUR EFFORT TO ESTABLISH APPROPRIATE ECONOMIC INCENTIVES IN THE MEDICARE PROGRAM AND TO ESTABLISH THE FEDERAL GOVERNMENT AS A PRUDENT BUYER OF SERVICES.

WE LOOK FORWARD TO WORKING WITH YOU ON THIS IMPORTANT INITIATIVE.

Senator **Durenberger**. Thank you very much, Mr. Secretary.

We have had the chance to visit on this subject in the past, and let me suggest to the members of the committee that we will use the 5-minute rule on asking questions, and we'll go around as long as there are 5 minutes worth of questions.

Let me devote a couple of questions to some of the testimony we will hear this afternoon from States that have experience with the DRG or some other form of prospective payment.

One of the suggestions that has been made is that you will experience some difficulty with the MEDPAR file, and various people have pointed out some of the deficiencies in the MEDPAR file system.

If you would explain for us how you are going to track data under this system that is accurate and reliable, it would be helpful to us.

Secretary **Schweiker**. Yes.

Well, basically we have several important things that we are going to do.

The MEDPAR data has been available for some time, and there has been a significant improvement in its quality since 1980. What we do now is take a sampling, based on statistics, of every fifth medicare case that comes through the system, so that any case ending in zero or five comes to our attention and goes into the new data bank.

So we really have a representative sample, which we believe is current, is contemporary, and quite helpful in arriving at a lot of the figures that we have.

In terms of the initial base, we had an input from 300-and-some hospitals, I believe 1.4 million records, and we put this information together in conjunction with the health specialists at Yale, and with the Public Health Service, and in conjunction with the private doctors that were involved.

I don't want to mislead anyone; this is a system that needs refining and improving, and I'm sure we are going to be learning as we go along. So it's not a complete and perfect system, but we have a data base and a lot more information than people thought, simply because we have been tracking it for about 10 years and have had a number of different studies involving it.

Senator **Durenberger**. Let me ask you another what might be called a tracking question.

There is obvious concern about what happens to quality of care as we shift to this kind of a system. The incentive is here for the hospitals to discharge early; the incentive is here for the hospitals to secure a portion of the treatment from, say, the part B portion of medicare, outside of the acute care system; the incentive is here for hospitals to engage in what is called DRG creep, that is, an upgrading the classification of a diagnosis from a less expensive one to a more expensive one; and the apparent need for utilization review of some kind in this whole system.

Would you speak to us in terms of your proposals in that regard, to monitoring and utilization review, and the concerns we all have for the peer review process?

Secretary SCHWEIKER. Well, first let me say that we do need a utilization review procedure. I think that's inherent in any system; it's certainly inherent in this system.

Second, let me say that there are a couple of mitigating factors that we think will be helpful:

We do have one pressure that I think is quite positive, and that's the malpractice situation. We believe, frankly, that because people can be sued, because there is a sensitivity to what rates people are paying for malpractice, there will be significant change in diagnosis patterns vis-a-vis the doctors, because they are subject to malpractice suits. If they try any shenanigans, the records will clearly show what's involved. And we can pretty well form a clear profile for anybody who wants to investigate malpractice. So we think that's a factor.

Third, we now have a mix of what that patient load of hospitals are. It's available to the intermediary. And anytime that a utilization review team or we ourselves want to go in and see if there has been a drastic change in length of stay or patterns to circumvent the system, we have a record now to go back and compare to, to see who may or may not try cheating.

Fourth, we did try to mess up our own system in one of our pilot runs and threw in a 30-percent error rate on clinical data. The interesting thing was, by throwing in a 30-percent error rate, the actual dollars paid to a particular hospital really didn't change much. In other words, because of the offsetting pluses and minuses, even a 30-percent error rate, which we certainly aren't expecting to get and don't hope to get, really wouldn't make much difference in the end product.

So with all those things in mind, we think it's something that we have to watch and be vigilant about, but we think it's doable. And New Jersey, I believe, has shown us that that has not been a problem in their State.

Senator DURENBERGER. Thank you.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Secretary, you mentioned that a difference today for a hip replacement could vary from $2,100 at one hospital in the country to $8,400 in another.

Do you have any data to show, assuming this proposal goes into effect, what the difference in payments would be for that DRG, calculating in the wage differentials and the capital cost differentials?

I am just trying to get a sense of what, as a practical matter, the agreed-to portion of this proposal, if implemented, is going to do to narrow that gap between $2,100 and $8,400.

Secretary SCHWEIKER. What we have basically done, and we will be glad to give it to the record because it gets awfully complicated, is we have calculated exactly what the financial commitment of these different DRG's are, and we have revolved them around factors of, say, 1.5 to 1 or .75 to 1, in terms of a 1 standard. And for each of these DRG's we can give you an index figure, say a .5 for DRG-22, .75, and so forth. So this becomes the mode, and we do have those, and we have those for each one.

In addition, on pricing, I think it's important to know how we are proceeding. We are not proposing setting up a different total pricing package than TEFRA has. So what we are basically going to do is say, OK, TEFRA provides this much money for the hospitals. And then we are going to go back to that pricing mode and work from that standard one deviation and all the implications of DRG, and bring out the same number of dollars to the hospitals that they get under TEFRA versus this, and then sort of work backward and set the rates.

So from there we can give you a breakdown of each of the rates, based on this statistical analysis.

Senator BAUCUS. Could you tell me, for example—you may not have it, but if you do have it I would like to hear it—what will the hospital receive today that is presently charging $2,100 for a hip replacement? How much more will that hospital receive? And conversely, how much less will the hospital receive that is today charging $8,400 for a hip replacement?

Secretary SCHWEIKER. I guess the best way to do it would be to get it for the record, because it would depend first of all, are they a teaching hospital; it would depend, second of all, where their geographical area is; and third, it would depend on which kind of hip replacement operation it is. But we will get it for the record, Max, and give it to you.

[The information follows:]

The "weight" assigned to a hip replacement is 1.5, which means that this type of surgery, without complications, is one-half times more expensive than the average Medicare case.

The average payment rate, nationally, for hip replacement surgery, without complications, is $4,500.

Under the Administration's proposal, the national rate would be adjusted to reflect area wage differences: For the highest wage area, the wage adjustment would result in a 40-percent increase in payment over the national average, or $6,300 for hip replacement surgery. For the lowest wage area, the wage adjustment would result in a payment rate that is 40 percent less than the national average, or $3,200 for this type of procedure.

The payment would, therefore, range from a high by $6,300 to a low of $3,200, depending on a hospital's location.

Senator BAUCUS. I assume that the difference in cost is very much geographic; that is, the east coast hospitals charge more than west coast——

Secretary SCHWEIKER. You have two variations here. One is the labor rate, and of course that can depend on whether you are a rural or urban area, and so that's a factor.

Now, one thing that does become a factor here is that some areas of the country have a longer length of stay than some other areas of the country. This would be one gap that we would like to close, so that we have a rather uniform length of stay. So you would see a difference here as to what the traditional patterns would have been in terms of length of stay. Now, that's one area where the gap, hopefully, would change.

Actually, you know, the interesting thing is there is more of a variation within States than across the country. It gets back to just the way the whole system is.

Senator BAUCUS. What are some of the causes for the variation? You say most variations are within the State. Are those variations for the highest cost procedures in urban areas as opposed to rural areas?

Secretary SCHWEIKER. Well, the first one would be labor costs, there is no question. And that's why we want to account for that.

And keep in mind that is 60 to 80 percent of a hospital bill. So if you have a rural area with low labor rates, that would be a factor, versus a high urban hospital.

On the other hand, a lot is practice and tradition—what the traffic will bear and what we've normally paid. So it's a combination of labor and what the traffic will bear.

Senator BAUCUS. Have you looked at some exemption or break-even or cut-off for rural hospitals, let's say hospitals with 50 or fewer beds?

Secretary SCHWEIKER. Well, they would come under the sole-source provider classification, so they, frankly, would be protected.

A rural hospital would really be protected in two ways. No. 1 is as sole-source provider. If they are the only one providing the source, they well may have higher costs.

Senator BAUCUS. What is the protection of sole-source provider? Are they exempt?

Secretary SCHWEIKER. In other words, we would pay them a different rate than the standard DRG rate if they are a sole-source provider and can show some difference from——

Senator BAUCUS. What kind of different rate would that be?

Secretary SCHWEIKER. Well, current law would be where we are probably heading in that respect.

Now, they have one other protection, and that is, we have an outlier provision. We expect that maybe 2 percent of the people in the system will fall well outside the limits of an A-curve pattern. We don't want any hospital, particularly a rural hospital, to be stuck with excessive costs where a patient that has to be hospitalized for 6 months, even though the DRG on that particular case may be based on 30 days.

Where there is a clear outlier case, as we call it, that hospital will get paid for the outlier case, so that the small hospitals have some protection and know that if they have an atypical case that breaks the bank, we will reimburse them for it.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Senator Dole.

Senator DOLE. Well, Secretary Schweiker, I guess the primary question is: Has this new approach been discussed thoroughly with the different health care representatives—hospitals, other providers, physicians, public hospitals, small hospitals, new institutions, those who serve primarily indigents—I mean, have you had a pretty good discussion with nearly everyone in the system?

Secretary SCHWEIKER. We have tried, really, Senator Dole, to meet with them and talk with them extensively. And I think it's helpful to mention one of the groups, the public hospital group. When they first heard about this new system, they were quite concerned. We sat down with them, and a result of our discussions, frankly, was the outlier approach.

Public hospitals now have about three protections that I think have begun to satisfy their concerns. The first is, they are going to get paid for their case mix. They argue they have all the worst cases, and the most complications, cases that everybody shoves away. We said, "Fine, that's what a DRG with complications pays you for." So to some extent we load it in their favor a little bit, in that they get paid for that higher case mix.

Second, where you have a case where it might be a sole community supplier situation, we'll take a look at it on that basis, if there's really not much else available to people. So that's protection.

Third is outliers. We expect that public hospitals like that may have more than their share of outliers, the harder cases. We will reimburse them for that.

When they heard all of these approaches, they were reasonable, and I think we probably worked out some constructive cooperation on it.

Another one is teaching hospitals. We completely have excluded them and keep them under the present system. I think they are reasonably satisfied with that.

The American Hospital Association initially had their own proposal for prospective payment. We honestly differed with them. They now are taking a look at our proposal; they have two versions of it. And while we can't agree with them on the issue of having each hospital having its own DRG rates, which is something they obviously would like to see, they did ask us to take a look, "Is there a regional picture we ought to look at for the DRG?" We said, "Fine. We will look at it." We don't think that it's going to be a key factor. Of course, to answer Senator Baucus' question, we think there is more variation within a State than within a region. But we are going to get those figures and look at it, and if it's a factor we would certainly consider something like that.

So we have had a coming together with a lot of health care representatives. I can't say they are all advocates, but I think a lot of their concerns and fears have been expressed.

And we do have some strong support from hospitals in the private and public sector who think they are more efficient, who think they can hold their own, and think they will make out on it, frankly.

Senator DOLE. And I assume if we don't pass this issue, we continue what we did last year in TEFRA. Is that correct?

Secretary SCHWEIKER. Well, that's the problem. Not only are you continuing in that direction but you are getting to a totally stereotyped system where everybody has to fall into niches, where you continue to reward the inefficient, and where it becomes a totally regulatory mode.

I think one notable thing about this system is that it is one-half regulatory and one-half private. It's regulatory in the sense we set the pricing, but it's a private initiative in that they are free to utilize, manage, and do what they want with their setups.

If you don't go this route, you are surely going to a totally regulatory mode, with everybody falling into pigeonholes, and I think stifling the real health care incentives in this country.

Senator DOLE. And then, what about some States who have reimbursement systems—New Jersey, Maryland? I guess you have a DRG system in New Jersey. I won't get into that; Senator Bradley may want to address that.

But would you apply a DRG-based system to States which have already established their own statewide hospital reimbursement systems? And how are they going to be treated? What about other States who may want to adopt other plans afterward, if we pass this legislation?

Secretary SCHWEIKER. Actually, Senator Dole, we will do it in two ways:

We presently have authority on the books to continue a waiver procedure for States that want to go different routes. We intend to continue that.

Under the new proposal we will also approve State reimbursement proposals. We will continue that option for States that want to come in with systems of their design and choosing, that we feel very favorable toward, provided they do it on a cost-saving basis, which is very fundamental, and provided they try to integrate it into the system we are trying to work on so that we can have sort of one common approach.

Senator DOLE. Thank you, Mr. Chairman.

Senator DURENBERGER. Senator Long.

Senator LONG. Mr. Secretary, what you are doing here gives all of us cause to hope that you are going to be able to have a more effective program and contain the costs at the same time. And I certainly share that hope.

We have been trying on this committee for years to try to devise a scheme that would provide incentives for good hospitals to do a better job and at the same time be more efficient, and in doing so reduce the cost and provide a better service.

Now, we all hope that that can be done and that your plan will do that.

But I am just curious to know to what extent you have managed to test this thing out, to anticipate some of the frailties that will crop up when it's in operation.

For example, you know that there will be an incentive to reduce the number of days that patients stay in the hospitals once they are operating under this type of system. Can you tell me how many hospitals are now being paid under this kind of a system?

Secretary SCHWEIKER. First let me say that I have here a report that we did send to the committee. We have been looking at dozens, literally dozens, of different systems in the States through demonstration projects in the prospective payment areas, in some other areas, and specifically in the DRG area.

I think our best model obviously is in the State of New Jersey, because they were willing to undertake a whole statewide system. So I think we can point to New Jersey as a statewide system.

At the same time we point to New Jersey, I think it is important to say that there are some significant differences between our proposal and New Jersey's, but not in the basic pricing mechanism of DRG.

So when we make a statement, for example, Senator Long, that says that they haven't had a significant DRG creep problem, they haven't. They really can show us that that has not been a significant problem. I think they can also show us that over their several years they have been able to maintain quality of care, and that we would be very concerned about.

So we can point to New Jersey, I think, to look at the rough cut and also the real concerns that people might have.

Senator **Long**. Well, here are some of the problems you might want to make a note of. These are just four different problems that occur to me that you would have to struggle with, and I just wonder what your reaction to them is.

The first thing is the problem of admitting patients with a marginal need to be hospitalized. In other words, it seems to me that if you don't watch out the diagnosticians can fill the hospital up with cases that need not be there, or they can diagnose a person as having two things wrong with him that require treatment rather than only one.

The second is this problem of the transfer of patients if they become expensive. I understand some hospitals right now take the view that they are not equipped to handle certain types of difficult cases and that these difficult cases also tend to be the very expensive ones. Now where this would occur under the proposed payment system, it appears that we would have to pay twice the full rate. I assume we would be billed twice under this type of system, once by each hospital, and that we would pay each the full rate.

Also, hospitals could discharge and then readmit a patient so as to collect two full payments.

Fourth, hospitals could transfer costs out of the institution by leasing out their laboratory, and things of that sort, so that it need only provide a partial service while still receiving a full payment.

I would just be curious to know how you are planning to deal with those types of problems? That's four types, and I am sure the imagination of man could think of a lot more.

Secretary **Schweiker**. Well, under the diagnosis thing, for example, we really think that malpractice insurance is a pretty healthy threat here. All they have to do is get sued for cheating the system, and they are going to be out a lot of money.

So I think the malpractice insurance itself—they are going to have to fudge records if they are going to do diagnosis things, and they are going to have to go to malpractice. And I think patients are going to be very sensitive to being told they have things they don't have. So I think malpractice insurance is a healthy thing.

I think, second of all, we now have a case-mixed profile of each hospital. We have every comparison we can make to what the hospital did before and after the system; so, if they are going to mess up the system, we can nail them based on the old profile.

Third, in terms of admitting patients, it's significant that we are going to pay patients for being discharged. We elected not to pay patients on admittance, because we thought that would push the incentive for admittance. By pushing it on the discharge part of it, we believe the emphasis will be a little more reasonable for being discharged as the incentive as opposed to being admitted.

On the expensive cases, I think we take care of that in two ways, Senator Long. We have a whole system that rewards the complex cases. We pay for complex cases. We'll give you more money if you have a complex case. So I think that legimately protects the patients that didn't want to get looked after before.

Second, we have the outlier provision, and that says that if you are going to have a patient that is there for 3 or 9 months for good reason, we're going to pay. And we're going to pay that hospital.

The hospital is not going to lose money on that patient; it's going to make some money.

So I think these are safeguards; but I want to be fair and say, "Yes, you need utilization review," and, "Yes, you're going to have to look at your profile," but at least you have a trigger, you have an index, you have a handle. You have something the administrator and we can get a hold of instead of just a big ball of mush, which is all we have now and can't do a thing about it.

Senator **Long**. My time has expired. Thank you.

Senator **Durenberger**. Senator Bradley, if you want to open with an opening statement as well as a question, you are free to.

Senator **Bradley**. Thank you very much, Mr. Chairman.

Let me say that I think a prospective DRG system is a very encouraging approach, and I hope we are able in the committee to work out many of the questions that still need to be answered before we can go to a Federal piece of legislation.

In New Jersey we have had, I believe, a relatively good experience with this approach. I think that we can learn from some of the problems that developed in New Jersey as we move to apply a DRG system nationally.

But this is the direction I think that the committee should go in, because the health care costs have been escalating almost beyond belief at a time when most other costs have come down dramatically.

Mr. Secretary, you mentioned that there were some differences between the program that you have proposed on the national level and the program that has been in operation in New Jersey, and that is correct.

The primary difference is that the national program is a single-payor, whereas New Jersey is all-payor. If you have only a single-payor essentially medicare, what will prevent cost shifts to other insurors, in your view?

Secretary **Schweiker**. Well, I think first of all we would expect that some other systems of payors will begin to piggyback on our system. In other words, we feel that our system has some real advantages, and we believe that our system, since it is a target and a handle and a specific case in point, will now become a basis for some of the other systems to look at their costs, and in fact will be a standard and a model.

While obviously anybody can shift costs anywhere if they want to, we believe that other people, having been alerted by our prudent-buyer system, will also decide that they may want to go the prudent-buyer route.

So that's a factor. But we think there are some real incentives now for industry, that is paying such a big share of the bill, and for States, through their medicaid program, to begin to piggyback onto this kind of a system.

Senator **Bradley**. Your answer is, there is no way to prevent the cost shift under the present plan. Except by example of effectively reducing costs for medicare recipients, essentially, what you would be doing is encouraging other insurors to approach hospitals and to bargain more heavily for reduced costs. Is that the idea?

Secretary **Schweiker**. Exactly, Senator Bradley.

We have become, now, the target. And we can say, "Look, we can show that across this country we are able to get a delivery and a technique that provides $3,000 for this kind of a basic treatment."

Now, every system in the book and a lot of businesses are going to ask why is their system costing $5,000 for this type case or procedure when everybody else is paying $3,000? We have never had that kind of a comparison. I think that kind of cost comparison will be a valuable tool.

Also, I want to point this out: There is nothing to preclude a State from doing just what New Jersey did. In other words, if cost shifting would become a problem, States would be perfectly free to apply for a setup very similar to New Jersey's, and we would look very constructively at that again. They would have the same option that New Jersey has, if they want to do that.

Senator **Bradley**. If you found that the hospital was being paid on the DRG basis for its medicare recipients and it chose to try to cost shift for the other patients, would there be States in which the insurers would not have the capacity to go to the hospitals and bargain strongly? Do you see any States where that might occur; where the insurers essentially would be the prisoners of the cost shift?

Secretary **Schweiker**. One of the things that I probably didn't point out is, I pay 40 percent of all the hospital bills in the country and industry pays about 60 percent, or 55 percent.

And having met with the Business Roundtable and the chamber and the NAM, I think you are going to find a very enlightened industry grouping out there who is going to start just what we are doing, now that we have given them a role model. And I have gotten a lot of encouragement from these groups that they are going to go back to their group plans and their insurers and do just what you suggest as a way to proceed.

Senator **Bradley**. Could you give me some idea of how many? Would they be doing it as an association, as a group, or would it be done on an individual-insurer basis?

Secretary **Schweiker**. Well, they are going different ways. Some of them do it as a metropolitan-wide grouping, because that's the way the business and industry labor grouping is.

Some of them are looking at it on a State basis. I have had some inquiries from some States that want to do it. And some of them are doing it on a single provider with their insurance carrier basis. So we sort of have three movements.

They have formed a lot of things called business coalitions. I could give you a whole list of new business coalitions that are formulated just for this problem. And now we give them the vehicle and we give them a pricing mechanism, and they have never had that before.

Senator **Durenberger**. Senator Mitchell? I'll make you the same offer: If you want to take the time to do an opening statement, we will leave it outside the 5-minute rule. Thank you for being here.

Senator **Mitchell**. I don't have an opening statement, but I do want to welcome the Secretary and wish him the best in his new endeavor.

Secretary **Schweiker**. Thank you.

Senator **Mitchell**. We are certainly sorry to see you leave. You have done an outstanding job.

I want to talk about one of the problems that has been identified and ask if you could be specific on how you propose to deal with it? It is the problem of small rural hospitals which, from my standpoint, we ought not to include in the new prospective payment system because it cannot provide enough support for them.

Could you tell me please, as specifically as you can, how your plan proposes to deal with this problem?

Secretary **Schweiker**. All right. First of all, we are going to have a sole-provider exemption procedure. So, where a community hospital or rural hospital is a sole provider within a certain distance, and it's the only source of hospital care, we in essence will use the present system which basically is a charge system based on their costs.

Where they are a sole provider and where access to care is a critical element, we will give exceptions based on that particular provision. So, that's No. 1.

Senator **Mitchell**. In effect, they will be exempt from these provisions?

Secretary **Schweiker**. Right.

Senator **Mitchell**. Well, what do you mean by a certain distance? Is there now some precise formula?

Secretary **Schweiker**. We are thinking in terms of 25 miles. Now, I might say we haven't formulated a lot of these details, including this, but 25 miles is in current law, and we would probably pick up that 25-mile definition. It would be our rough guesstimate.

Senator **Mitchell**. We have a number of such hospitals in Maine, and I would like, if I could, to submit information to you regarding their characteristics, the areas that they cover, etc. I would also like to ask you to take this information into account when you establish any such distance formula.

Secretary **Schweiker**. One other thing. I forget if you were here when I answered the question about outliers. Basically what this means is that one thing that can really hurt a small hospital is they get a patient who stays for 4 or 5 months, and is sort of atypical, and he's the exception to all the statistics.

We are going to have an outlier procedure, so that where we clearly have a clear-cut outlier case, where he defies the odds, we will reimburse for that case to that hospital.

I think in many cases it does the small hospitals, because when that kind of a case comes up they won't get penalized or hit, they'll get, in essence, rewarded for helping and staying with that patient who is sort of an atypical, abnormal case in the throwout thing.

So between the outlier technique and the sole community provider exemption, we believe there are mechanisms to help your rural hospitals.

Senator **Mitchell**. I just want to understand clearly what I think you are saying on the distances. Let's assume it is 25 miles. If there is any other hospital within 25 miles, then a small rural hospital would not be deemed a sole provider. Is that the standard you are suggesting?

Secretary **Schweiker**. Well, let me say that is the quick definition, yes. I still have an exception authority, and I could, under certain conditions—suppose you have a tremendous snow condition, like in Maine, and suppose snow becomes a problem because of the year-round weather, I could still grant an exception even though it's within 25 miles because there was some extenuating weather factor. So I still have the authority beyond 25 miles.

Senator MITCHELL. And I think that's precisely the case. I will submit some additional information to you in that regard.

One of the committee staff identified a series of problem areas, and I don't know if you have covered this particular one since I came in late. It is the whole problem of beneficiary costsharing. There is pressure from the hospital industry to bill patients for amounts over and above what is paid by medicare. They also want to use other means to in effect increase the amount which they can receive.

Now, I know that's one of your objectives anyway, to try to get more cost sharing by beneficiaries as a means of reducing the increase in demand.

I would like to ask you to comment on that specifically, sir.

Secretary SCHWEIKER. Well, we crossed that issue very early on when we first formulated this plan. Now, I am opposed to charging the patient any additional money beyond what the DRG pays the hospital. I would be totally opposed to that.

Senator MITCHELL. Fine.

Secretary SCHWEIKER. And our system does not provide for that.

Senator MITCHELL. It does not provide for that?

Secretary SCHWEIKER. Does not provide.

Senator MITCHELL. Does it prohibit it?

Secretary SCHWEIKER. Yes.

Senator MITCHELL. It does? All right. And how will that be enforced?

Secretary SCHWEIKER. Well, anybody who did that obviously wouldn't get paid by us. They wouldn't get paid a DRG if they did it.

Senator MITCHELL. Well, that's when you find out about it; but do you have some mechanism for auditing or for reviewing or for enforcing to make certain that it doesn't happen?

Secretary SCHWEIKER. Well, they would be in violation of law, so we have all remedies under the law to go back and get the money, both through civil suit or through criminal suit. But it's in violation of law.

Senator MITCHELL. Well, as we both know, the fact that the law is violated, and somebody in authority finds out and does something about it, are two very substantially different questions.

Secretary SCHWEIKER. Right.

Senator MITCHELL. You are creating a new category of violation here, and I'm just wondering whether you intend to accompany it by any mechanism for determining when and whether such a violation occurs.

Secretary SCHWEIKER. Well, we will certainly have an administrative procedure, Senator Mitchell. I think it is a very valid point.

I do want to say this: I would think that a patient getting a bill in addition to the other bill will be a key factor in this case, because you can't hide a bill very well, and it's the first thing they talk about.

So we would make it very clear in our administrative procedures and our listing to the hospitals that that is the case.

Senator **Mitchell**. Well, I very strongly encourage you to do that, Mr. Secretary.

I guess my time is up. Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you, Senator.

Gentlemen, I am informed the Secretary has to leave us in about 3 minutes, but we will have some questions to submit in writing.

[The questions follow:]

Senator **Durenberger**. Senator Baucus.

Senator **Baucus**. Mr. Secretary, one question that I have, a basic fundamental one, is: What assurance do we have that the DRG proposal, the prospective reimbursement proposal, still provides payments to beneficiaries on the basis of health considerations rather than on the basis of some political budget considerations that OMB or the Congress otherwise makes?

It seems to me if the proposal is for the Congress and the administration to set a fixed amount, and over the years to revise those amounts upward, or how much upward, there is a strong tendency for these to be budget determinations rather than determinations of expenditures related to health needs of beneficiaries.

What measures do you have to provide that these amounts that we spend on the DRG's are based on health considerations and not on budget considerations?

Secretary **Schweiker**. First of all, we started out on the very important premises that the system that we are going to put in place would not be saving money to the budget over the present TEFRA system. If we came in and said, "OK we're going to save 10 percent over TEFRA," I think you could legitimately accuse us of doing exactly that.

We are proposing an equal cost system, in terms of TEFRA versus this. That's the first thing.

The second is, the reason I selected this system is that the whole tendency of this system is to pay more for people that are sicker, pay more for people who have complications, pay more for people who need the latest technology. We pay more. The present system doesn't target it that way, per se. We will reimburse more for sicker people, which I think is a pretty fundamental concept and touches on it.

Third, I believe by providing the outlier payment we really are saying that your sickest people are really going to be taken care of. So I think there are sort of three parts of it.

Now, let me say, in any system somebody can come back and do that, Senator Baucus. But I certainly have been opposed to that. I think the Department's position is clear, that we wouldn't support it; but, like everything else, you have to be vigilant about it.

Senator **Baucus**. I understand. It might make some sense to draft some kind of standards or some sort of health organization review of all this, to help assure that we don't decide too much on budget considerations.

Secretary **Schweiker**. Well, I do support the utilization review mechanism.

Senator **Baucus**. Thank you.

Senator **Durenberger**. Senator Bradley.

Senator **Bradley**. Thank you, Mr. Chairman.

Mr. Secretary, as you know, there have been some problems with program implementation in New Jersey. As a result there has been a phasein both in the number of hospitals covered and in the DRG rate.

Do you think it's possible to go to a national DRG in 1 year, given the present data management and administrative capabilities in HCFA?

Secretary **Schweiker**. One big thing that New Jersey is doing that we do not propose to do, that I think answers part of this question, New Jersey in addition to the DRG system has a budget-review system for each of its hospitals.

Senator **Bradley**. Yes.

Secretary **Schweiker**. We are not proposing a budget-review system. Frankly, if we had a budget-review system for each hospital as New Jersey had, it would be a tremendously difficult thing for us to do nationally. New Jersey may be able to do it for a 100 hospitals, but we wouldn't.

So by clearly singling out the DRG system as opposed to both the DRG system and a budget-review system that Jersey has, we think we eliminate a lot of the administrative burden, a lot of the startup problems.

Senator **Bradley**. So you would want to implement the DRG rates, for all hospitals in 1 year?

Secretary **Schweiker**. Well, within the year that we used TEFRA as the target. So to some extent we are using the TEFRA base for the year and giving hospitals a year to gear up, to look at, and to work on the TEFRA base.

Senator **Bradley**. I understand.

Secretary **Schweiker**. So we would expect that they would have the best part of a year to really get the thing started from when we phase it in.

Senator **Bradley**. One last question. Would you tell us again how you can assure quality of care? How will the monitoring be done so that we can be assured that premature releases and excessive transfers of patients and all of the things that theoretically could happen do not occur?

Secretary **Schweiker**. Well, I think we should depend on a utilization review mechanism.

Senator **Bradley**. So the PSRO's, the PRO's, would be the monitoring mechanism?

Secretary **Schweiker**. Well, I like utilization review, and I personally advocated the PRO. I lost the budget battle in that regard, but we do need a utilization review mechanism, whether you do it with PRO's or some other route. And I would be the first one to admit that.

Senator **Bradley**. Thank you.

Senator **Durenberger**. Are there any other questions of the Secretary?

Dick, let me just make one observation, because this may be the last time we will see you here.

I well recall 2 years ago when you sat here about this time, telling us we didn't need the regulatory system because in 2 years we were going to have competition, consumer choice in health care, and so forth. I know deep down in your heart you didn't believe that. [Laughter.]

Senator DURENBERGER. You believe in competition and consumer choice, but you believed in that the way we believed that we could balance the Federal budget in those same 2 years.

I think today you made a very realistic comment in response to a question; that is, you characterized this part of the system as "half regulatory and half private," and it seems to me that that is the transition phase that we are going through, and that items like peer review that we talked about are regulatory in nature but they are a way to transist into a private system.

So I hope when you leave your recommendations behind and think about the good things and the bad things, that you will send one of them to Dave Stockman and to the President, and whoever else makes decisions on the nature of some regulatory mechanisms.

But on behalf, at least, of this subcommittee, we really do appreciate your commitment to health care policy while you were a Senator, and certainly the commitment that you brought to the Department of HHS as a Secretary.

Secretary SCHWEIKER. Well, I thank you, and I want to say it has been a privilege to work with this committee, because I think this committee has been very positive and constructive in dealing with this whole range of problems.

I am delighted to see you start the hearings today and to see your very positive approach, and I am very confident that what you are going to come up with in this committee is going to be very helpful to the system. I am just glad to see you on that track, and I thank you.

Senator BRADLEY. Mr. Secretary—if I could, Mr. Chairman—let me just say that even though you are leaving Government service, I hope that you will still continue to vacation at the Jersey Shore. [Laughter.]

Secretary SCHWEIKER. My kids will see to that, Senator.

Senator MITCHELL. But now he will be able to afford to come to Maine. [Laughter.]

Secretary SCHWEIKER. Well, they do a little skiing, too, Senator Mitchell, so we're all right. [Laughter.]

Senator DURENBERGER. Thank you, gentlemen, and thank you, Mr. Secretary.

Secretary SCHWEIKER. OK, thank you.

[Secretary Schweiker's answers to additional questions submitted by Senator Heinz follow:]

1. Q. What are the current regional hospital cost differences and differences in percentage of short 1 and 2 day hospital stays? How much regional price variation will remain after area wage adjustments are made?

A. For 1980, Medicare average hospital cost per case had the following relative differences by region:

		Relative 1980 Level
	Nation	100.0
1.	New England	110.2
2.	Middle Atlantic	110.0
3.	East North Central	109.4
4.	West North Central	92.4
5.	South Atlantic	97.3
6.	East South Central	89.6
7.	West South Central	91.2
8.	Mountain	93.8
9.	Pacific	109.0

We currently estimate that the percentage of Medicare short (less than 3 day) hospital stays by region varies as follows:

		Percent of Medicare Stays Under Three days
	Nation	12.6
1.	New England	11.9
2.	Middle Atlantic	10.0
3.	East North Central	10.4
4.	West North Central	13.0
5.	South Atlantic	12.0
6.	East South Central	11.3
7.	West South Central	14.4
8.	Mountain	17.0
9.	Pacific	18.4

No. 1 continued:

After area wage adjustments are made, we estimate that the following variations by region will exist in average 1984 Medicare Prospective Payments per case:

		Estimated 1984 Medicare Average Payment Level
	Nation	$2856
1.	New England	3147
2.	Middle Atlantic	3142
3.	East North Central	3124
4.	West North Central	2638
5.	South Atlantic	2780
6.	East South Central	2556
7.	West South Central	2605
8.	Mountain	2679
9.	Pacific	3112

2. Q. How will the HHS DRG prospective payment plan account for differences in severity of illness between general hospitals and major area medical centers or teaching hospitals which frequently have more seriously ill patients, including transfers from other hospitals?

A. The prospective payment plan will account for differences in severity of illness between general hospitals and major medical centers or teaching hospitals several ways.

First, the DRG's themselves have been developed in a way which separates the major diagnostic categories (MDCs) into classes which result in higher payment rates for more costly types of cases. To the extent that these hospitals treat proportionately more higher payment rate cases than do general hospitals, they will be compensated more.

Second, we propose to make extra payments for each case involving necessary care for more than 30 days beyond the national average length of stay for its DRG.

Third, in recognition of the higher costs of teaching hospitals, we propose paying teaching hospitals a lump sum to cover Medicare's share of their direct costs of conducting approved General Medical Education programs (intern and resident salaries, etc.) plus a factor representing the indirect or extra costs of care in such institutions. That factor will vary according to the hospital's ratio of residents and interns in approved GME programs to its number of certified beds.

3. Q. Is HHS planning continued studies on measures to identify severity of illness, and what data will HHS be collecting under the proposed prospective payment plan on the impact of severity of illness?

A. Yes, HHS is planning continued studies to identify variation in severity of illness and associated effects on hospital care costs and payments.

One project will be examining whether the disease-stages may be related to significant cost variation within DRGs. Another project is examining Urban Public Hospitals, including whether they incur higher costs because the populations they serve are more severely ill.

HCFA has also established a priority to fund grant applications for projects to develop, refine and test ways to modify prospective systems according to measurable cost differences associated with differences in relative severity of illness.

In a data sense, HCFA will be obtaining clinical information for up to five diagnoses and four surgical procedures per case.

4. Q. How will the HHS plan monitor and control "management by admission," where hospitals may avoid or transfer more severely ill patients?

A. Admission pattern monitoring (APM) will be used to detect changes in hospitals' admission practices. APM is a process which involves data analysis and review of admissions and readmissions to determine where inappropriate action may have occurred. The purpose is to determine if a pattern of change in admissions occurs and the magnitude, nature, and cause of the change. HHS has already begun to implement this technique APM under the current TEFRA cost limits: Experience gained will be used to make any needed refinements for a prospective system.

5. Q. What are the payment levels for pacemaker procedures under the DRGs?

A. There are four different DRGs into which cases involving pacemaker procedures can fall. The following table presents our present estimates of the 1984 national standard "prices" for each.

DRG	Abbreviated Name	Estimate National Standard Price*
115	Permanent Cardiac Pacemaker, with Acute Myocardial Infarction (AMI) or Congestive Heart Failure (CHF)	$11,996
116	Permanent Cardiac Pacemaker, without AMI or CHF	$ 8,641
117	Cardiac pacemaker Replacement or Revision, excepting Pulse Generator replacement only	$ 5,712
118	Cardiac Pacemaker Pulse Generator replacement, only	$ 5,338

*These "prices" cover all payments to the hospital, including the cost of obtaining the pacemaker. These would, of course, be adjusted by the area wage index which has a range from 0.7245 to 1.6758, and any "outlier" payments.

6. Q. How will fraud and abuse, such as unnecessary pacemaker implants or replacements, be monitored under a prospective system?

A. HCFA soon will publish updated guidelines for the medical necessity of cardiac pacemakers and cardiac pacemaker implants. These guidelines will permit Medicare contractors to determine clearly whether an implant should be covered. Total cost limits and the rate of increase control under TEFRA and a subsequent hospital prospective payment system will provide hospitals with a strong incentive to be prudent purchasers of high cost items such as pacemakers. Additionally, the Office of the Inspector General has authority for investigating and taking appropriate action against individual providers where fraud and abuse can be substantiated.

7. Q. How does HHS specifically plan to monitor quality of care and utilization, other than monitoring hospital admission patterns?

A. In addition to monitoring hospital admission patterns, we have several other activities, which when combined with admissions pattern monitoring, constitute a reasonable approach to assuring quality. They are:

-- the use of new sampling techniques for assessing the appropriateness of a hospital day. These techniques are described in more detail in my testimony to you.

-- the proposed revisions to the hospital conditions of participation will remove many process requirements on hospitals, but also will place increased importance on addressing and resolving quality assurance issues. Failure to do so could lead to Program exclusion.

8. Q. The budget proposal requests the elimination of PROs. If PROs are eliminated as the Administration's, FY '84 budget requests, what entity will perform their medical review functions? And how will these functions continue to be performed by any entity without additional funds?

A. The Medicare Fiscal Intermediaries will assume responsibility, as they do now in the absence of a PSRO, for medical utilization review of questioned claims. Because of the sampling approaches that can be applied, assumption of this responsibility will not be a major cost concern.

9. Q. Will HHS continue to support State options to develop all-payor prospective payment systems provided by current waiver authorities? If so, will HHS allow experimentation with other forms of prospective payment, or will States be restricted to DRG-based systems?

A. The Department of Health and Human Services (HHS) will continue to support the development of Statewide, all payor, prospective payment systems under the waiver authority of 402(a)(1)(C). As explained in the "Statement of Policy" dated October 8, 1982, in order to be considered for approval under Section 402(a)(1)(C), a demonstration proposal should:

- Be applicable Statewide;
- Result in combined Medicare and Medicaid savings each year;
- Use diagnosis-related groups (DRGs) as the unit of payment;
- Limit sharing or risks; and
- Not preclude HMOs from negotiating their own rates.

HHS is also interested in testing capitation methods and other highly innovative competitive prospective reimbursement systems. HCFA intends to focus the majority of its study in Statewide rate setting to an evaluation of alternative systems for paying for hospital services on a diagnosis related basis.

Section 101(c) of TEFRA also gives the Secretary programmatic authority to give waivers for alternative reimbursement systems. The system must apply to at least 75 percent of hospital inpatient revenues in the State; must treat payors, hospital employees and patients equitably; and the Secretary must be satisfied that the system will not result in greater Medicare expenditures over a 3-year period.

10. Q. The HHS plan expects only one-half of one percent of all Medicare patients in hospitals to be "outliers." How does this compare with New Jersey's experience with their "outlier" Medicare population?

A. Our Medicare prospective payment proposal would define as "outliers" all cases involving necessary inpatient care which extends 30 or more days beyond the national average length of stay for its DRG. We estimate that approximately 2 percent of all Medicare cases will be "outliers."

Our definition of "outlier" cannot be directly compared with that used in the New Jersey system. There, both upper and lower "trigger points" have been established for each DRG. These points have been set so that between 30 and 35 percent of all cases fall outside them.

Being an all payor system, New Jersey adopted an outlier policy consistent with equity among various payers. This kind of approach was developed in New Jersey on short stays largely as a means of improving small-payer equity. For most hospitals, Medicare is not a small payer.

11. Q. What specific adjustments will HHS be making to cover the costs of outliers?

A. "Outlier" cases (those extending more than 30 days beyond the national length of stay for the DRG) would be paid the DRG rate plus a per diem amount which is estimated to cover the variable costs for care during the extra days. This per diem amount would equal approximately 60% of the average per diem for that DRG.

12. Q. How will the HHS plan address the costs of care for patients who are "backed up" in hospitals awaiting placement in other institutions?

A. Hospital days used by a patient awaiting discharge to another institution are included in the DRG rate of payment.

Senator Durenberger. We may ask the Acting Secretary to come back on February 17, just by way of general information, because we will learn more from other witnesses and have more questions.

Our next witness is Congressman Ron Wyden from the State of Oregon.

Ron, welcome to the hearing. We appreciate your interest in health care policy, and your anxiety to testify here this morning is very appreciated by the members of the subcommittee and the full committee.

You may proceed with your statement.

STATEMENT OF HON. RON WYDEN, CONGRESSMAN FROM THE STATE OF OREGON

Mr. Wyden. Thank you very much.

Mr. Chairman and members of the subcommittee, I am very pleased and honored to be able to participate in the subcommittee's hearing today on prospective payment.

I think the question we've got in front of us, health care financing, is one of the key pocketbook issues in this country today. Health care costs, and particularly hospitals costs, as we know, have just gone through the roof in the last decade. In 1982, health care cost the Government and private industry $287 billion, twice as much as just 5 years ago.

With the Federal deficit expected to top $200 billion this year and our economy still locked in a recession, it seems to me that this is a cost that neither the Government nor individuals can afford; so we've got to come up with workable solutions.

I think we also know that achieving that goal is not going to be an easy task. For 6 years the Government has tried to find solutions to rising hospital costs, and for 6 years we have essentially failed.

First, there was cost-containment. That was proposed in 1977. The hospital industry essentially saw that as a straightjacket, and not surprisingly, it did not pass.

The next effort was the so-called voluntary effort. That didn't work particularly well, either. Although some facilities participated to their best ability, I think we know now that others didn't, and in the long run very little changed.

Last year as part of the Tax Equity and Fiscal Responsibility Act, Congress approved a plan to place a lid on reimbursement for routine hospital costs. Almost everyone agreed then that really wasn't a change, just a capping of costs.

So what we need in the 98th Congress is major surgery.

First, the Government is going to have to ax the current cost-based reimbursement system, the system under which hospitals are paid after-the-fact a percentage of what they claim is service costs. Cost-based reimbursement essentially rewards the inefficient and penalizes those people who are doing a good job.

In place of cost-based reimbursement, the Government should institute a new prospective payment system that would give the providers incentives to sit down with the Government before the services are provided and work out a reasonable payment schedule for those services. That's what I proposed to do last year when I introduced H.R. 5084, and it's what I'll propose again today when I introduce in the House later today prospective payment legislation.

Now, we know prospective payment works because it has been proven to work. Seven States and 30 municipalities have prospective plans now, and most, if not all, have been able to reduce the annual rate of increase in hospital costs from 2 to 6 percent below the national average.

The reason prospective payment has worked is because States and local entities have been allowed to develop their own plans that address the needs of those local areas. New Jersey and Maryland have developed prospective payment plans that are based on diagnostic related groupings and cover all payors. Rhode Island negotiates to establish what is called a maxicap, or a maximum increase in the statewide budget for all hospital care for the coming year.

Because I think that this flexibility is absolutely essential to the success of a national prospective payment system, the legislation that I am going to introduce allows States to tailor their prospective payment plans to the unique needs of their given area.

Now, I am not alone in this belief that a State kind of focus is important. Alice Rivlin, Director of the Congressional Budget Office, testified late last year in support of the very same principle, that the States should have a role in prospective planning.

I think it doesn't take a genius to figure out that not all health care providers are cut from the same mold and that Government makes a mistake to try as a matter of health policy to put square pegs into round holes. What is good for consumers and providers in my own State of Oregon isn't necessarily good for those in New York or Texas, and the same is true for Michigan or California.

Now, my plan does recognize the need for establishing basic guidelines. In the bill that I will be reintroducing today we prevent cost-shifting, the dumping of medically needy patients and cost overruns, and I think finally laying a foundation for delivering quality medical care that Americans want at reasonable prices.

Now, it goes one step further, in addition to this role for the States, my bill provides all-payor coverage for States that opt to develop a State prospective payment plan.

All-payor coverage is important, and this is another feature that Alice Rivlin testified late last year was essential to a good prospective payment bill.

All-payor coverage recognizes that in order to win the war, we are going to have to do battle with all the sources of increased hospital costs, including medicaid and other third-party payors, and also medicare.

My bill recognizes that cost-shifting inflates the cost of private insurance plans, and that means more costs for the patient, the insurance companies, and employers. In my home State of Oregon alone, third-party payors were forced to pay an additional $120 million in hospital costs last year due to cost overruns imposed by medicare, medicaid, bad debt, and charity cases.

Mr. Chairman, I think the plan that I am going to introduce today is a good one, but I'm not so narrow-minded as to think that other plans don't have merit. I very much welcome the opportunity to work with you, with my colleagues in the House, and members of the administration to develop a plan that is going to add up and is going to be able to get through the Congress. But I want to say, in just making some very quick concluding remarks, that I've got some real reservations right now about some of the specifics of the administration plan as it presently stands.

For one, I am concerned whether it contains a realistic proposal for dealing with the issue of capital. It seems to me we cannot allow capital costs to go absolutely unchecked, as the administration's bill does, when capital investments mean an additional 30 cents of costs per dollar annually for medicare.

I am also concerned that the administration's DRG proposal doesn't include a provision for States to develop their own prospective payment plans.

Most important, I am concerned that the administration's DRG proposal is a medicare-only plan, while the model that everyone says it's based on, which is the New Jersey model, is in fact an all-payors plan much along the lines that my bill will call for. While the New Jersey program has worked well using the DRG arrangement, there are no assurances that the administration's plan will work as well, or even work all together, when it is limited just to medicare and doesn't deal with all-payors.

At the same time, there are a number of features in the administration's plan that I can support, strongly. I am pleased that the requirement of taking medicare assignments as the total amount receivable from beneficiaries is in the administration's plan. There are also efforts to protect against dumping and skimming of undesirable patients. I think there are some features there, that they are sure to make it into a bipartisan consensus effort to get prospective payment legislation out of the Congress.

Finally, the administration's plan, like mine, is a good step. It is moving toward change in the existing cost-based reimbursement system, a system that I am convinced, ever since the days when I was the director of the Grey Panthers out in Oregon, rewards inefficiency and is going to lock us into greater and greater problems in the years ahead.

So I very much appreciate the chance to come here, Mr. Chairman, and should you or other members have any questions I'll try to respond.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Congressman Ron Wyden follows:]

TESTIMONY BY

CONGRESSMAN RON WYDEN

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to participate in the subcommittee's hearing on prospective payment.

The issue before us today -- health care financing -- is a pocketbook issue. Health care costs -- and particularly hospital costs -- have shot through the roof over the past decade. In 1982 alone, health care cost the government and private industry $287 billion, twice as much as five years ago.

With the federal deficit expected to top $200 billion this year, and the economy on the skids, this is a cost neither the government nor individuals can afford. That means we must come up with workable solutions -- and soon.

Unfortunately, achieving that goal is no easy task. For 6 years the government has tried to find solutions to soaring hospital costs, and for 6 years we have failed.

First, there was cost-containment, proposed in 1977. This approach was viewed as a straightjacket by the hospital industry -- and not surprisingly, it failed.

Then there was the so-called voluntary effort -- which didn't work either. Although some facilities participated to their best ability, others did not -- and in the long run, very little changed.

Last year, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA), Congress approved a plan to place a lid on reimbursement for routine hospital costs. But virtually everyone agrees that this is not really a change, just the capping of costs. What is needed is major surgery.

First, the government must ax the current cost-based reimbursement system -- under which hospitals are paid after-the-fact a percentage of what they claim a service cost. Cost-based reimbursement gives hospitals incentives to keep costs high because the more a hospital charges, the more money it is reimbursed.

In place of cost-based reimbursement, the government should institute a new prospective payment system that would give providers incentives to sit down with the government before services are provided and work out a reasonable payment schedule for those services. That's what I proposed to do last year when I introduced HR 5084, and what I'll propose again today when I reintroduce prospective payment legislation.

We know prospective payment works because it has been proven to work. Seven states and 30 municipalities have prospective payment plans, and most, if not all, have been able to reduce the annual rate of increase in hospital costs from 2 per cent to 6 percent below the national average.

The reason prospective payment has worked is because states and local entities have been allowed to develop their own plans that address the needs of the local area. New Jersey and Maryland have developed prospective payment plans that are based on diagnostic related groupings (DRGs), and cover all payors. Rhode Island negotiates to establish what is called a maxicap, or a maximum increase in the statewide budget for all hospial care for the coming year.

Because I believe that this flexibility is critical to the success of a national prospective payment system, the legislation I am reintroducing allows states to tailor their prospective payment plan to the unique needs of their area.

I am not alone in this belief. Alice Rivlin, Director of the Congressional Budget Office (CBO), has come out in support of a state role in prospective planning.

It doesn't take a genius to figure out that not all health care providers are cut from the same mold, and government makes a mistake to try as a matter of health policy to put square pegs into round holes. What is good for consumers and providers in Oregon isn't necessarily good for those in New York or Texas. And what is good for those in New York or Texas is not necessarily good for those in Michigan or California.

My plan does recognize the need for establishment of basic guidelines. By preventing cost-shifting, dumping of medically needy patients and cost overruns, it lays a foundation for delivery of quality care at reasonable prices.

And it goes one step further -- it provides all-payor coverage for states that opt to develop a state prospective payment plan.

All-payor coverage is important, as Alice Rivlin of CBO has acknowledged. All-payor coverage recognizes that in order to win the war, we must do battle with all the sources of increased hospital costs -- including Medicaid and other third-party payors, as well as Medicare.

My bill also recognizes that cost-shifting inflates the cost of private insurance plans, and that means more costs for the patient, the insurance companies and the employer. In my state alone, third-party payors were forced to pay an additional $120 million in hospital costs last year due to cost overruns imposed by Medicare, Medicaid, bad debt and charity care.

I believe my plan is a good one, but I am not so narrow-minded as to think that other plans do not have merit. I welcome the opportunity to work with my colleagues in the House and the Senate and with the Administration to develop a plan that adds up and can make it through Congress. But I must confess to having some reservations about some of the specifics of the Administration plan as it presently stands.

For one, I am concerned whether it contains a realistic proposal for dealing with the issue of capital. We cannot allow capital costs to go absolutely unchecked when capital investments mean an additional 30 cents of cost per dollar annually for Medicare.

I also am concerned that the Administration's DRG proposal does not include a provision for states to develop their own prospective payment plan.

Most important, I am concerned that the Administration's DRG proposal is a Medicare-only plan, while the model that it is supposedly based on -- the New Jersey model -- is an all-payors plan. While the New Jersey program has worked well using the DRG set up, there are no assurances that the Administration's plan will work as well -- or at all -- when it is limited to Medicare.

Nevertheless, there are a number of features in the Administration's plan I support. For example, it continues the practice of hospitals being forced to accept Medicare assignment as the total amount receivable from beneficiaries, it guards against widespread dumping and skimming of undesirable patients and it encourages cost efficiency.

Most important, the Administration's plan, like mine, is a good first step toward changing the existing cost-based reimbursement system -- a system which rewards inefficiency -- to a prospective payment system -- a system that rewards efficiency and honors quality health care.

Thank-you.

Senator **Durenberger**. Maybe you can say I'm wrong in this, but this is not the kind of issue that reelects people. It doesn't have all the pizzazz that some other issues have. So I think those of us who are involved on this side welcome your particular interest and that of many of your colleagues on the House side.

Let me just react to a couple of things that you mentioned, because you may not have been here at the beginning of the testimony.

We agreed with a couple of major decisions that the administration made, and that was to leave out or pass through issues like capital costs and teaching costs.

In addition to that, we agreed with their recommendations not to make a hasty move to an all-payors system.

This subcommittee has conducted and will conduct more hearings in the future on these other issues related to medicare. We recognize the desperate needs that are going to face medical education in this country. We are no longer going to be able to lay the cost of medical education on sick persons, and we've got to find some alternative financing mechanism.

The whole area of capital is one we need to better understand before we start altering the entire reimbursement system.

So we certainly welcome not only your interest but your comments here today. You may want to react on the all-payors proposal, because you feel strongly about it. I am personally very interested in exploring the all-payor issue.

But until we learn more about running a prospective system on a nationwide basis, as opposed to running it on a single-State basis, would it not be preferable to take the prospective without the all-payors?

Mr. **Wyden**. Senator, I would make just one comment—and that's an awfully thoughtful analysis—my all-payors portion applies just to those State plans. I am not talking about setting up a national all-payors system, which of course would be much more complicated.

My bill really differs from the administration's in two material areas: One, we would like very much to let States write their own prospective payment plans. To do that, they've got to phase in all payors. And it seems to me that strikes a reasonable compromise. On the one hand, it lets us take a flexible approach; it gives States a chance to be the architects of plans that are tailored to their own regional needs. And it also gives us a chance to work out some of the kinks in the all-payors area, because the States would be doing it, and we wouldn't be trying, as part of this prospective payment effort which you and I both agree is so important, we've got to do it now—I am not talking about setting up a national all-payors system in the legislation I am introducing at this point.

Senator **Durenberger**. So you are recommending that there be some specific State waiver provisions. And do I understand you, that if we do have State waiver provisions in the law that the waiver would be conditioned on that State plan having an all-payors provision in it?

Mr. **Wyden**. That's correct.

Senator **Durenberger**. All right.

Senator Baucus.

Senator **Baucus**. Thank you, Mr. Chairman.

Ron, would you eventually go even further, along the lines of what the chairman feels, that eventually there will be a national all-payors system?

Mr. **Wyden**. Absolutely.

Senator **Baucus**. And your bill is an experiment, and the States could really experiment with the direction they are going in, instead of going all the way immediately. Is that correct?

Mr. **Wyden**. I think to really deal with the guts of the cost-shifting problem, eventually we are going to have to have an all-payors system for the country.

Now, that's bound up in a lot of other questions, Senator, that we are going to be debating: The role of competition in the health care system, a wide variety of approaches. But absolutely, at the end of this process of surgery on the health care system to make it more efficient and use our resource better, I very much think we have got to all-payors.

Senator **Baucus**. Instead of a State waiver system, though, why don't we allow the industry to move in this direction on its own? From the comments of the Secretary, which I'm sure you heard this morning, if various groups—business groups—are already meeting and beginning to explore moving in that direction, assuming this legislation proposed by the Secretary is adopted, isn't that enough? Isn't it going too fast to go to the State waiver?

Mr. **Wyden**. I don't think it is enough, Senator. I am very much pleased about these efforts of local coalitions—the business, labor, consumer coalitions—to move toward all-payor arrangements and other kinds of arrangements tailored to their areas, and in fact I think much of that can be done without any additional legislation whatsoever, but I think it's not enough.

And particularly if we take on medicare, which is a tremendously fast-growing program, now over $50 billion, I think we've got to begin to factor in the all-payors concept.

I've tried to take a moderate position, not starting a national system overnight when it's urgent that we get this off the ground, but at least to make it a prerequisite for the States that would like to take an innovative approach and do it on their own.

Senator **Baucus**. You've obviously given a lot of thought to this. What is your view toward some kind of a peer review system, the old PSRO system and the new system we passed last year? Do we need that, do you think, assuming this legislation is adopted?

Mr. **Wyden**. I think we have to have a role for those services at the outset. I wouldn't want to get into a long-term projection of what their role might be, but certainly at the outset; yes. I think we need those kinds of services until we get this off the ground.

Senator BAUCUS. Do I understand you to mean a national all-payors system to be one where the Government sets the DRG's? As you visualize an all-payors system, who sets the DRG's?

Mr. WYDEN. The National Government would. And I think that's why it's so important for us to begin to go to an all-payors system and to begin that effort in the 98th Congress.

It seems to me that the message has gotten out all over the country that the Government's resources are finite, what the Government is going to pay is going to be limited, and now we've got to make sure that the Government is going to limit what it is going to pay, and that we don't continue the same inefficient patterns by just passing it on, by just cost-shifting to the private sector and ultimately to all the senior citizens as far as the medicare program is concerned.

Senator BAUCUS. Why not let the various payors set different DRG rates? Is there a danger in a national system of too much regulation again, and that there will be no competition?

Mr. WYDEN. Two comments on that, Max. I think one is, it might be too complicated. I think we are already running the risk right now—I know that I met with providers when I was home last were—already there is concern that it is way too complicated as it is. So I think if we do anything with respect to the DRG system we ought to simplify it, reduce it to fewer categories than it has, and my guess is that it might be an administrative impossibility.

Let me go to one other point, and that's on the competition. I think there is going to be, as we get the prospective reimbursement legislation out this year, a much greater effort to bring competition into the health care system.

I know I am working on a bill right now to do that, Senator Durenberger is, and probably a whole slew of Members of Congress are.

I think, to lay the groundwork for a good competitive system, you need this prospective payment effort this year.

Senator DURENBERGER. Thank you very much, Congressman Wyden.

Mr. WYDEN. Thank you.

Senator DURENBERGER. The next witness is Michael D. Bromberg, the executive director of the Federation of American Hospitals.

Welcome, Michael.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. BROMBERG. Thank you, Mr. Chairman.

I would like to submit our statement in full for the record and try to summarize briefly the parts we feel most strongly about, if I may.

Senator DURENBERGER. Without objection, your statement will be made part of the record.

Mr. BROMBERG. We would like to start off by saying that one of the problems, probably the single most serious problem we see with the present law as amended by TEFRA, is that the target rates of increase for hospitals under medicare are now calculated on each hospital's own base. That means, very simply, that low-cost hospitals are penalized and high-cost hospitals have more dollars to work with, since 8 percent on twice as much money turns out to be a lot more dollars.

That is not only a geographic problem, State to State, so that a State like Montana and even Minnesota on the average would get a lot fewer dollars than States in the Northeast, but it also affects small hospitals and rural hospitals in a more disadvantageous way than large hospitals.

We felt last year and still feel that the most important provision in TEFRA was the one mandating the Secretary to develop a prospective proposal by the end of the year. And now that that proposal has been submitted to you, we view it as a most promising one and urge you to adopt it with recommended changes.

We have outlined in our testimony, on page 3, some of the general principles we thought should be followed. Without saying which ones have been met and which ones we think have not been met, we think overall it is a very constructive idea as submitted by the Secretary.

We believe that hospitals should have the opportunity, but not the guarantee, that their financial needs can be recovered under a system.

We believe that beneficiaries should have protection from catastrophic costs, and we believe the Government should have budget predictability. I think that those principles, at least in part, have been met.

The price-per-diagnosis system, while not necessarily the one we would have recommended, is one we can support, because we believe it is clearly preferable to the existing system.

We also recognize that this is a cost-control device, and, while a few years ago or even today we may not like it, I have to stress that it is far better and more equitable than the present system.

We also recognize that while it's cost controls on hospitals, it's really meant to get at physicians and their behavioral patterns.

The whole point of replacing cost reimbursement with a fixed-rate-per-case of any kind is to provide an incentive to restrain spending. Now, while some of that involves management techniques and efficiency and productivity, once you finish with that what's left in bulk is utilization of services.

I have heard this morning several questions and answers that started with phrases like "hospitals may discharge patients early" and "hospitals may order too few or too many tests," and I just can't stress enough that hospitals legally and morally can't and shouldn't do any of those things—physicians do them.

A hospital administrator may go to a physician and say, "I hope you do a lot more tests this month," and maybe the Doc will and maybe he won't, but the hospital can't tell the doctor what to do.

Under the new system they may go and say to the doctor, "We hope you do a little less and get the patients out earlier, because isn't good for us," but they can't tell the doctor to do it legally, nor would I think you would want that to happen. I don't think we want to substitute lay judgments for medical judgments.

That concerns us, because there are some risks there: If the doctors do not change their behavioral patterns we get left holding the bag.

But again, it is better than the present system, it's in the right direction, and for that reason we support it.

Now, in our testimony we have 10 recommendations for amendments, beginning on page 6. I won't bore you with all of them, but I would like to just mention a few:

It has been mentioned this morning that there is some concern about the reliability and accuracy of the data. Therefore, our first recommendation is that at least once every 5 years that data be recalculated, that we not get stuck with a base of 1980 and never change it, that a few years from now we look at it again. We know that the total dollars aren't going to change, but within DRG's there may be relative changes.

Second, the word "phase-in" has been used, and we believe that in the past that has just been used to slow down legislation, water it down, and not really put in the right incentives.

On the other hand, I think the concern that some hospitals may get penalized too much the first year or two can be overcome by the second recommendation, which is a hold-harmless provision. This committee put one into TEFRA a year ago; we would urge you to look at it again and say that at least in the first year or two of the program no institution should get less than it got the year before. If that is a monetary problem in terms of the budget, perhaps 110 percent of the DRG rate should be the ceiling on the hold-harmless, but some kind of hold-harmless.

Our third recommendation I think is the most important. It's the one we're most afraid of, and it's the one that Senator Baucus mentioned this morning, that we don't want to start with a price system that looks promising and fair only to find in the second and third year some future Secretary, because the statute is vague, decides there will be no increase, "because OMB said so."

So we would urge you to put in minimum protections and guidelines for an annual increase. We recommend the market-basket-plus one, plus—based on the advice of an outside commission, any other technological-intensity additions for new approaches. We may discover new kinds of laser-beam surgery, and a certain DRG may have to be more expensive. That should be built in.

And, No. 4, judicial review and an exception procedure.

The other six I won't go into at length, except I would like to mention those that relate to cost-shifting; we have heard a lot of talk about it this morning.

I just think we ought to understand from the beginning that medicare is paying right now about 10 percent less than costs, which means that someone else in the private side is paying that 10 percent as a subsidy or a hidden tax, call it what you will.

That is not to say that the other payors, these insurance companies that have been referred to, are helpless, that they are sitting out there begging for Government protection in an all-payors system. There is nothing to stop them from putting ceilings on what they pay, from negotiating rates, from finding preferred provider organizations and doing constructive things. I just didn't want to leave that cost-shifting argument as one that is impossible to solve.

In conclusion, one last point. We want to stress that while we have been for prospective payment for about 15 years, we have supported steps in that direction, we want to see this system put in place and have the committee do the oversight work to refine and improve it rather than phase it in slowly.

But we don't want you to think that we're here saying this is the solution. This is not going to solve the health cost problem, it's not going to solve the medicare trust fund problem; it's one very good step, long overdue, but until the issue of demand is addressed and until the tax structure is looked at, which tells people like employers and employees that health insurance is free and that there is no limit on how much one can have, and until we look at vouchers and until we look at cost-sharing, we will not have taken the same incentives that you are now studying for hospitals, and we will not have given them to physicians and patients.

You have to find a way to tell the physician and the patient the same thing you seem to be telling us today, which is, "We want to give you an incentive to restrain spending."

It's a good step, but I think you have to address the other two, and I hope you will as we move on.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman and Members of the Subcommittee, my name is Michael D. Bromberg, Executive Director of the Federation of American Hospitals.

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing 1,045 hospitals with over 120,000 beds in the U.S. alone. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

Congress recently cut the Medicare program by $2.9 billion for fiscal year 1983, hospitals incurring $700 million of those 1983 cuts. While Congress made some changes in Medicare reimbursement to hospitals by expanding Section 223 limits to cover all costs on a per-discharge basis and redefined reasonable costs by eliminating the nursing differential and the private room subsidy, we still have a cost-based retrospective payment system which historically has fueled health care expenditure increases and fails to provide incentives for efficiency and reduced utilization.

However, Congress did take an important step towards developing a reimbursement system for Medicare which the Federation has long supported which offers economic incentives for more efficient delivery of health care. The tax equity bill allows incentive payments for those hospitals with Medicare costs below an established target. Hospitals below their target rate would, for the first time, be allowed to retain half of the difference between their actual Medicare costs and their target rate, thus providing a financial incentive for hospitals to lower costs by rewarding them for doing so. Although still based on a retrospective cost reimbursement system, this represents an important step towards more sound policy in

Medicare reimbursement. One major problem with this current provision, however, is that the target rate of increase is calculated on each hospital's base costs. This penalizes low cost hospitals because their allowable dollar increase is smaller than facilities with higher base costs.

The most important provision in the bill, we believe, directs the Secretary of HHS to develop and report to the Congress by the end of 1982 a prospective payment plan for Medicare reimbursement to hospitals. That report has been submitted and we believe it outlines a promising legislative proposal for changing the incentives of the Medicare payment system.

The Federation has long supported a prospective payment system and the elimination of retrospective cost reimbursement. We think it imperative that Congress act quickly to implement such a system so that we do not once again have to face the annual charade of tinkering with the present reimbursement system, making arbitrary cuts in the Medicare program by redefining "reasonable costs," and without achieving necessary fundamental reform of the program.

A new system acceptable to government should certainly include budget savings and predictability, administrative simplicity, incentives for efficient delivery of services, and the ability to implement the new system quickly and consistently with the competition principles supported by the Administration.

Hospitals essentially desire many of the same principles. Hospitals will certainly want assurances that the new system would be equitable, will allow hospitals the opportunity to recover their full financial requirements and involve less regulation. Other third-party payers will look at the system to see whether it minimizes cost shifting. Beneficiaries will certainly be concerned about the scope and equity of any cost sharing elements as well as freedom of choice of providers.

We believe the concerns of all parties involved can be satisfied by adhering to the following guidelines:

-- The payment system should pay a fair price sufficient to allow efficiently and economically operated hospitals to provide quality services at a fair return on investment from the government and beneficiaries.

-- The payment system should be fair and equitable and should include an exception/appeal process to include judicial review. It should recognize the full economic requirements of hospitals, the geographic differences in these economic requirements and the special circumstances of individual hospitals.

-- The payment system should be basic in design, administratively simple and economical to operate and should avoid complex formulae.

-- The payment system should be based on objectively determined prospective rates to be adjusted at least annually in order to encourage optimum planning and the predictability of expenditures and income.

-- The payment system should encourage through economic incentives, including consumer cost sharing, the efficient utilization of services by beneficiaries and physicians.

-- The payment system should allow hospitals the ability to bill patients for the difference between a fair price and Medicare's payment to reduce cost shifting. The payment system should contain appropriate provisions for beneficiary catastrophic coverage.

-- The payment system should allow reasonable time for the development and implementation of a base year, appropriate roll-forward provisions, and a conversion period from the present to the prospective payment system with appropriate input by hospitals.

These principles would assure hospitals of the opportunity to recover their financial needs (although it would not guarantee recovery if their prices are too high). They would assure beneficiaries of catastrophic protection which they do not have under current Medicare law. They would minimize the need to cost shift by redesigning the time of copayment. They would save dollars and provide budget predictability to government. Finally, they are consistent with the competition strategy of the Administration stressing consumer choice and incentives for restraint in utilization.

The Administration has recommended a Medicare prospective payment system based on a competitive price per diagnosis. That type of Medicare system, while clearly a cost control device, is preferable to the existing system of cost reimbursement with ceilings because it offers incentives and rewards. We consider it conceptually as a positive reform.

We also recognize that this type of cost control device, while imposed on hospitals, is really intended to change the behavior and practice patterns of medical staffs. The whole point of replacing cost reimbursement with a fixed rate per case is to provide an incentive to restrain spending. Some of that spending involves management decisions but a larger part involves utilization of services and procedures which are ordered by physicians. This concerns us but we believe the alternative -- continuation of cost reimbursement with ceilings -- is worse.

Some proponents of a broader regulatory approach advocate a federal system which applies to all payers or state rate control programs as the answer to increasing health care expenditures. However, a review of state rate controls indicates little difference in expenditure growth on a per capita basis between the seven states with controls and all other states. 1980 per capita hospital costs rose 13.6 percent in rate control states compared to 13.7 percent in all other states -- an insignificant difference. When New York is excluded, the per capita increase was 1.2 percentage points greater in the rate control states -- 14.9 percent compared to 13.7 percent for non-control states. Maryland also incurred a per capita increase of 13.9 percent, which is higher than increases for other states.

Hospital care is more expensive in states with mandatory rate setting programs. In 1979, per capita hospital expenditures for the seven states with mandatory programs were $305 versus $272 for non-mandatory states.

New York, which has the oldest and most advanced rate setting program, also has a hospital system which is in very poor financial health. Between 1974 and 1978, New York voluntary hospitals had to use almost $500 million in hospital reserves to finance operating losses. At that rate, it will only take 15 years before the total equity of all the 222 voluntary hospitals in New York is consumed. Although demand for services and patients served increased during the 1974 to 1978 period, the number of voluntary and public hospitals declined 5.4 percent.

Although New York has reduced its hospital expenditure growth rate more than any other mandatory rate setting state, the penalty is probably more than other states would be willing to bear. Liquidating a hospital system to save money is like demolishing the rooms of a house to cut energy costs.

This regulatory approach cannot be effective without sacrificing quality, eliminating innovation and competition, and we urge you to reject it.

There has been considerable concern that inadequacies in Medicare and Medicaid reimbursement have resulted in some hospitals raising their charges to payers who pay for care on a charge basis. There is similar concern that if Medicare should proceed to pay hospitals on a prospective DRG basis, this cost shifting would continue and perhaps be increased. It should be understood that if the incentives in a plan are in the direction of lowering hospital costs generally, all payers not just Medicare would benefit from the lower costs. In any case, if DRG-based prospective rates are appropriate for Medicare, it does not seem reasonable to fail to adopt them purely on cost shifting requirements. It seems more appropriate for each party to determine its own payment rates for services.

Nor does it seem reasonable to make any improvement in the Medicare payment system contingent upon the federal government's taking responsibility for controlling all hospital payments for all hospital services. It is a clear existing federal responsibility to assure that programs through which it pays for care do so equitably and prudently, but it is a far different matter for the federal government to take on the greater responsibility of controlling all hospital payments for all parties, thus changing hospitals to the status of a public utility.

We urge Congress to act upon the Administration's recommendations with deliberate speed so we can achieve the necessary future budget savings in the Medicare program through thoughtful, participatory, reasonable reform.

Our association supports the general direction of the Medicare prospective payment system proposed by the Department of Health and Human Services. Notwithstanding a number of our concerns about the validity of the data base, adjustments to base prospective payment schedules, the treatment of new technologies, and the need for an equitable appeal mechanism, we urge the Committee to approve the Department's plan with the following modifications designed to improve the system:

Recommendation One:

The Department should publish the proposed fiscal 1984 DRG price lists so they can be reviewed by Congress and the hospital industry prior to adoption. The charge data file and DRG cost weights used to determine the Medicare prospective price schedule per diagnosis should be updated in the future -- at least once every five years -- to utilize more accurate base-year data when available.

Recommendation Two:

Hospitals should be held harmless to each institution's prior year's actual average cost per admission for the first two years of the prospective payment system to assure an orderly transition to a more accurate data base.

These first two recommendations are made to compensate for errors in the existing data files. These errors relate to incorrect reporting by hospitals of principal diagnoses and incorrect coding by hospitals or intermediaries. Many of these problems could be overcome if accurate information could be submitted and verified prior to development of the final price per diagnosis and cost weight index. We propose that the DRG system be implemented without delay but that it be modified over a multi-year period with more current information. The use of future data would improve accuracy and the hold-harmless provision would allow earlier implementation.

Coding bias can be minimized by recalculating payment rates when clinical data for post effective date periods becomes available. This would allow the Administration's DRG based payment plan to be implemented in at least two stages, with reduced precision being acceptable for the first stage in the interest of replacing cost based reimbursement as quickly as possible. A fair exception process and appeal procedure are particularly important during this initial period of transition.

Recommendation Three:

Congress should incorporate a basic formula for updating payment rates in the statute to prevent arbitrarily low forecasts of inflation or failure to recognize effective technological improvements. In addition, Congress should require HHS to reflect in future years' payment rates any errors made in forecasting increases for prior years. Annual price adjustments should be implemented for all DRGs according to such a Congressionally mandated formula with additional adjustments for specific DRGs determined by the Secretary with outside expert advice to reflect technological advances.

Base rates per diagnosis should be adjusted annually on a prospective basis to reflect changes in both hospital specific inflation (the market basket of goods and services purchased by hospitals) and new technologies reflecting changes in treatment, equipment, and intensity of services. The minimum annual adjustment should equal this market basket plus at least one percent for general intensity plus an amount for additional intensity for all DRGs and specific DRGs where needed to assure quality of services.

An external body of experts should be utilized in the determination of these important factors. That external body should consist of physicians, hospital managers, and health economists.

This recommendation is based on our concern that inadequate price adjustments for intensity and new technologies could discourage development and implementation of new treatment techniques.

Recommendation Four:

Hospitals must have the right to judicial as well as administrative review of decisions which determine the rates of payment, as well as an exception procedure for unique circumstances in which patient care could be adversely affected.

Recommendation Five:

New institutions should be exempt from the system for three years and provision should be made for recognizing certain major operating cost increases associated with new capital. Major expansion or renovation, for example, should be recognized as creating a new provider status. Newly constructed facilities, with high start-up costs and low occupancy should receive an adjustment to the DRG rate recognizing their higher than average start-up costs.

Recommendation Six:

The Department should study methods for developing an equitable system for future use in incorporating medical education services and capital requirements in a prospective payment system. These variable costs cannot be reflected in a system based on averaging because of differences among institutions. For these reasons, educational and capital needs should be separately reimbursed on a cost basis during the initial years of any prospective payment plan.

Capital costs must include depreciation, interest, and return on equity for investors as historically reimbursed by the program. We are prepared to work with the Department and Congress to develop a totally prospective payment system, including capital and teaching; however, we do not believe an equitable prospective system covering these services can be developed or implemented during the early years of a prospective system.

Recommendation Seven:

Hospitals should have the right to bill patients for the difference between Medicare payment rates and charges applicable to private patients for similar services not to exceed a reasonable catastrophic ceiling per case.

This authority is necessary to prevent deterioration of quality resulting from arbitrarily low Medicare payments or annual rates of increase in those payment levels. In addition, since the Medicare rate will not be a true market price because DRG rates are based on existing contractual allowances, patient cost sharing will produce competition among hospitals while permitting patient freedom of choice in selecting institutions with greater amenities or more expensive treatment capabilities. Patients would be protected by a catastrophic ceiling per admission. Finally, this type of cost sharing would give physicians and patients incentives to shorten lengths of stay and utilization.

Recommendation Eight:

Congress should direct the Department to reduce paperwork and eliminate all cost reporting not absolutely necessary for determining capital, educational, or other costs not covered by the prospective price schedules. The initial DRG prices should include a factor to cover initial conversion costs, such as computerized systems.

Recommendation Nine:

The Department should continue to study the need for adjustments to the price per diagnosis schedules and the feasibility of adjustment for factors such as severity of illness and regional differences in the market basket for purposes of annual price changes.

Recommendation Ten:

The Department should also study and recommend prospective payment plans for those specialty hospitals, such as psychiatric, children's, and rehabilitation facilities and outpatient hospital services, which do not easily fit in a DRG-type system.

One final note of caution. Prospective payment is a long overdue Medicare reform but it will not solve the problem of unrestrained demand for health services. If everyone is to be guaranteed unlimited health services, then cost control systems cannot solve the government's budgetary problems. If some limits on the amount of government financed health services are acceptable, then the question is how to allocate limited tax dollars.

As Congress turns its attention toward development of a prospective payment system for Medicare, it should also understand that while prospective payment is an important reform, other changes are needed to restrain health cost increases. In particular, we believe Congress should address broader health policy issues by bringing marketplace competition to and restraints on utilization of our health care system by enacting the following legislative proposals: a ceiling on tax-free employer purchased health benefits designed to encourage the offering of multiple insurance plans; benefit redesign to require reasonable cost sharing by Medicare beneficiaries during the first 30 or 60 days of a hospital stay up to a catastrophic level in order to encourage restraint in utilization; and a voluntary Medicare private insurance option.

These changes in conjunction with a Medicare hospital prospective payment system will help achieve a rational health policy, dealing effectively with the underlying problems with our current system and alleviate the need for future drastic, arbitrary cuts in the Medicare program.

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Senator **Durenberger**. Thank you, Mr. Bromberg.

Senator Dole.

Senator **Dole**. Thank you, Mr. Chairman.

I need to go testify on social security on the other side, but that last statement you made was of some interest. Are you willing to put a cap on some of the health care costs that are deductions to the employer and tax-exempt income to the employee?

Mr. **Bromberg**. We have supported several pieces of legislation, including Senator Durenberger's. We have supported—our board—now for 2½ years a resolution which says we call for a Federal ceiling on the amount of health insurance which is tax exempt to the employee.

And we do think you should look at that, because that will stop cost shifting. That will tell the insurors that they are not helpless and that they had better get their premiums below $175 a month, and do it themselves in an innovative way by negotiating rates, rather than waiting for some Government commission to do it. Yes.

Senator **Dole**. Well, I share that view, and hopefully we can do something this year.

Senator **Durenberger**. Thank you, Mr. Chairman.

Senator Baucus?

Senator **Baucus**. Mike, one question I think on an item that is in the recommendations you didn't cover, and I believe it deals with a recommendation that new hospitals be exempted. What is the rationale behind that?

Mr. **Bromberg**. Well, let me answer that, and also in the context of the discussion before on capital.

You know, we can pass through all the capital in the world—the depreciation, interest, return on equity, rent—and it doesn't do a hospital any good if their rate of increase under TEFRA or under prospective is the market basket plus one, because the dollars will not be there to finance that new service.

So, for example, if you spend $1 million to buy a CAT scanner, and the depreciation and the interest is passed through; no problem. How do you pay for the $100 per test that it is going to cost you to hire the technician to run that machine if you are stuck with a market-basket-plus-one rate of increase, which we have now?

You have already effectively, more than anyone realizes, restrained capital to the point where we are worried about it and there is a shortfall. So when people worry about the 6 or 8 percent of capital spending, we're much more worried about the 94 percent of operating costs associated with it.

Second, new hospitals less than 3 years old traditionally have very high startup costs. Their occupancy rates for the first year or two may be 30 to 50 before they get up to 70 or 80 percent in the third or fourth year, which means their costs are going to be extremely high during that initial period, not to mention the new construction costs.

And as in past law under 223 and in other sections where Congress has exempted hospitals less than 3 years old and/or given them an adjustment, we think that that would be appropriate for prospective.

On a related matter—I may be wrong on my assumption, but it has to do with the way in which we might be constraining the availability of capital—I am informed that now in New Jersey the New Jersey hospitals have a pretty favorable bond rating when they go to market by comparison with other parts of the country. Is that in some way related to the existing system in New Jersey? Or is that a fallacious assumption for us to make?

Mr. **Bromberg**. No; the assumption is correct; but I believe it is because of something that we're not in favor of, which is because New Jersey is an all-payor system.

When you have a State rate review and budget review system, which this is not, you are assuring safety. You are saying, "No one is going to go under; we're not going to let you go under; it's a public utility; everybody is going to float by," and it's very anticompetitive. When you do anything that is competitive you insert in the system more risk, and the riskier it is, the tougher it is going to be to get a higher bond rating. And that's the choice you have to make when you are balancing competition and regulation.

We prefer the competition. We think that a bond rating and the access to capital of a hospital ought to come from demonstrated efficiency, which is where it comes from in every other industry.

If a business goes to a bank and wants to borrow money, the bank wants to know "Are you operating at a decent margin." If a hospital does the same thing, we think that test should be relevant. If a hospital is losing a lot of money their bond rating shouldn't be high.

Now, under a competitive DRG price, some hospitals are going to come in under it and some aren't.

Senator **Durenberger**. But doesn't that say that somebody who is setting bond rates has not quite got the competition message that you and I and a few other people think is the future of health care? The bond-setters are looking at basically a regulated system in which everyone is going to be paid the same thing for the same service, guaranteed. Yet some of us believe we are moving to a more competitive marketplace in which there will be competition for the delivery of service, and that not all of those facilities are safe over a 20 year or 30 year period of time.

Mr. **Bromberg**. I think you are absolutely right, but I do think that the five or six—I think it's six—States now that have rate-setting commissions, most of which are in the Northeast, are and probably will be the least competitive as we move to a more competitive system, and the safety will be a factor there.

Senator **Durenberger**. All right. Thank you.

John.

Senator **Heinz**. Mr. Chairman, thank you.

Let me express my regrets that I wasn't here for what will probably prove to be the valedictory appearance of my fellow Pennsylvanian Dick Schweiker. I was called to the House Ways and Means Committee to testify on another small, unimportant issue—namely, social security reform. And so far, the reform seems to be going along pretty well.

I do have a number of questions, Mr. Chairman, that I would like to submit to Secretary Schweiker. They relate to some of the things that you and Mr. Bromberg have been talking about.

If I might, I will just briefly indicate a few of the kinds of questions, in case Mike would like to comment on them.

One happens to be the fact that east coast hospitals tend to have a much smaller number of 1 and 2 day stays than west coast hospitals, which is going to affect whether or not the payments made under the DRG's are going to be adequate to eastern hospitals.

Another question is that, for example, university hospitals such as the University of Pennsylvania Hospital have a larger percentage of severely ill patients in the DRG categories under review, and there is a question in my mind of how the DRG's are going to account for the differences in severity of illness between general hospitals and major area medical centers, teaching hospitals if you will or a subset of those, which frequently get the most serious cases—by the way, including transfers from other hospitals in their areas or regions.

There is the question of how we are going to control the management by admission, or the ping-ponging effect, where hospitals may avoid or transfer severely ill patients.

There is the question of how we are going to monitor fraud and abuse under prospective payments, which, Mr. Chairman, I fear is going to be rather difficult to really fully address, perhaps a little less so in the case of hospitals, a great deal more so in the case of skilled nursing facilities which simply don't have the kind of quality assurance and in some cases, I'm sorry to say, the kind of ethical standards that you find in the typical hospital.

In that regard, by the way, we will be having a hearing in the Aging Committee on Friday regarding the Autumn Hills Nursing Home. Texas has a prospective-payment system in effect for its nursing homes, and this one nursing home, starting about 3 years ago, got into trouble because a local prosecutor determined that, at least the allegation was, that due to the inadequacy of care, gross inadequacy of care, a number of patients had died, and this corporation was indicted for murder under one of the murder statutes—I don't recollect whether they were indicted for manslaughter or for a different-version statute.

The point is that here is a prospective-payment system, where clearly—if you believe the allegation—services that should have been provided weren't being provided, and very understandably—under prospective payment you don't pay for what you get, you pay for what you think you are going to get. And that's a very big difference, indeed, especially where you have a for-profit situation and an unscrupulous operator. This is not to suggest that that is the case with anybody who is for profit or that all operators are unscrupulous; they are obviously not.

Another question really grows out of the pacemaker hearings. I was dying to ask Secretary Schweiker, since medicare now pays between $10,000 and $15,000 for a pacemaker procedure, and we've pretty well documented that something about half that would be reasonable, which of those numbers he is going to pay under prospective reimbursement? The difference is about $1 billion a year to the medicare system.

Those are some of the questions that I wanted to really lay out. I will address them in more succinct form to the Secretary, but I thought, Mr. Chairman, it might be useful to get a few of those out on the table since we are going to have a series of experts before us this morning and at other times, and they may start thinking about those questions, because they are not exclusively questions just for Dick Schweiker, they are questions that we as a country have to address.

Senator **Durenberger**. We have prepared the Secretary for additional questions, but I noticed Mike has been taking notes as you have been asking them.

Perhaps you would like to respond to all or some of John's questions?

Mr. **Bromberg**. I would like to just make a brief response to a couple of them.

The whole general category of fraud and abuse, whether it is DRG creep or deliberately withholding services needed by a patient in order to profit, if you put those into one category I would make several comments about them:

No. 1, let's not forget that the present system is subject to fraud and abuse just as easily, and that the percentage of those who do it is small.

I think it is always dangerous to fashion legislation in such a way that you aim at the 1 percent instead of the 99 percent.

I think under the present system you may find fraud and abuse of overusing services. I find it ironic that I don't hear many proponents of HMO's say the same thing when we are talking about HMO's. It's the exact same incentive; and yet when you are talking about hospitals and nursing homes, they do.

Second, in hospitals it is physicians who make those decisions, not the hospitals. So you have that protection, certainly a safety valve. But obviously there are still going to be horror stories, and we ought to have protection.

I think the bottom line is, instead of spending their time auditing cost reports, from now on under a prospective price, where you don't have to worry about cost reports and have literally hundreds if not thousands of people in the Government doing nothing but that, they can devote their attention now to fraud and abuse, and to utilization, and maybe PRO's, instead of the incredible paperwork they are now devoting to it—that's No. 1.

In terms of the DRG creep in particular, one of the reasons we recommended recalculating these prices every 5 years is for just that reason; we know that there's a limited Federal pot of money out there, and we don't want the medicare trust fund to go broke any more than you do. And if there is a DRG creep, the easiest way to stop it is to recalculate the rates within DRG's, knowing that the total is going to be the same anyway. I don't think you will see that creep for that reason.

The management by admission is the same thing.

On severity, your point is very good about the university hospital, and I would broaden it so it applies to public hospitals and other hospitals, or even inner-city private, for-profit, or nonprofit hospitals that aren't teaching.

There are some people who believe there is a severity issue, and the patients do differ regardless of the diagnosis, but nobody knows what to do about it. Rather than hold up a piece of legislation over it, we have recommended that you mandate the Secretary to study it over the next year. There are people working on how to develop an index to find it. If one comes up, the Secretary ought to be ready to jump.

You know, we don't know to what extent the problem is. A lot of it is just gut feeling that it's there. So we think it ought to be looked into.

The last point that I will cover is your first point about the eastern seaboard's length of stay.

I have made it a habit whenever I go to New York to ask friends of mine in hospitals, mostly doctors, in New York, "Why is the length of stay here"—it's much more than that; it's really, I think, something like 8 or 9 days compared to 5 in California—"Why is your length of stay 2 full days above the national average?" And I can't tell you how many times I have heard this answer: "Mike, it's because the rate commission here pays per diem. And don't let anybody kid you, the incentive here is 'keep them longer' because your real high costs in a hospital are the first 3 days. And unlike everywhere else in the country where you want to get them out fast for that reason, in New York you want to keep them."

Plus, there are other reasons. There is the nursing home shortage that you are aware of in New York. I don't know what the number is—I am no expert—but some significant population in the hospital every day in New York really should be in a nursing home; but there isn't one. And there are many other problems.

Senator HEINZ. Mike, from the statistics I've seen, they suggest that it is the people who would normally be in for a very short stay that skew the average number, and that for some reason, perhaps having to do with the way health care is regulated in the West, there are large numbers of people who go in for a 1- or 2-day stay. Those same kinds of admissions seem to result, or apparently the same kind of admissions seem to result, in something a good deal longer than a 1- or 2-day stay, and maybe that is the reason.

Mr. BROMBERG. Another thing, though, is one of strengths of the Department's proposal—while I was no advocate of DRG's, the reason that the Secretary gave for choosing it is that it will take away the incentives to put in the short, easy case to make money, because you will get paid less for that case than you would under an average; whereas, if you have a tough case you will get paid more for it. And that's one of the benefits of price-by-diagnosis, rather than just *x* dollars for whatever the admission may be.

Senator HEINZ. If the chairman will give me 60 seconds more.

There may be other reasons for the length of stay. Let's take my home town of Pittsburgh, Pa. Frankly, we have a population in that area, because it is a coal-mining area, that have a particular set of health problems that people in California don't have.

To some extent, a lot of people have gone West or have gone to the Sun Belt who were kind of healthy and energetic enough, or deluded themselves enough, to think that they were going to have a better life there. And maybe they are, and maybe they are not, but there is some self-selection that takes place, too.

Mr. **Bromberg**. We think it's in part due to the absence of regulation in the West.

Senator **Heinz**. You may, but you may be wrong.

Mr. **Bromberg**. Yes; we may. [Laughter.]

Senator **Heinz**. Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you.

Senator Baucus.

Senator **Baucus**. Mr. Bromberg, would you expand a little bit on the ways we can assure that future Secretaries don't make decisions based upon the budget rather than on health needs?

Mr. **Bromberg**. Yes.

Actually, never before have we even thought of giving this kind of discretion. And to be fair, we haven't seen a draft of the bill yet, we've only seen this 200-page report; so I may be jumping to assumptions, and maybe they will put in specific criteria.

But the report simply says that the Secretary should make a judgment.

We think what you have done in the past in this committee was to put in, usually, a specific statutory guideline plus an exception procedure, and we think that makes sense.

We recommended market basket plus one, not because we think it's fair, we think it's very low, but because we know you don't want this bill to cost any money, you want it to be budget-neutral. And for that reason, since we are under a market basket plus one now, we put it in as a minimum. And we think it's very low.

But in addition, we think there ought to be a procedure whereby the Secretary, with outside help, some kind of—I hate to propose "advisory commissions" but that's one possibility; another is just that he consult outside experts—look at the technology within each DRG and see whether a particular DRG should be increased beyond the general increase of market basket plus one.

And finally, an exception procedure with an appeal procedure for unforeseen circumstances or sole community hospitals, et cetera.

Senator **Baucus**. What is your reaction to Congressman Wyden's bill?

Mr. **Bromberg**. Well, if the bill says what he says it says, it's present law. We testified on his bill on the House side, and we basically said we'd rather go with a medicare prospective payment now, because that's going to change the law. And what Congressman Wyden seems to be saying is, if a State wants to have its own DRG for medicare, it should be all payors. My understanding is that's what the present law and the present waiver authority is. So we can't fight with——

Senator **Baucus**. What is your reaction to it?

Mr. **Bromberg**. We don't want to encourage States to do it with Federal incentives like money or other carrots, however, because we don't think it's a good way to go. But if a State wants to do it——

Senator **Baucus**. Do you think we are moving toward or should move toward a national all-payor system?

Mr. **Bromberg**. I don't think we should move toward any all-payor system; I think a competitive system implies that there will be various methods and various negotiations, that you don't want to stop, for example, a business coalition member from negotiating a preferred provider arrangement or discount in one State like Oregon simply because they may have a rate commission which is setting a rate which takes away any incentive to be innovative. If a hospital knows it is going to get the rate, why should it negotiate a discount.

No; I don't.

Senator **Baucus**. Thank you.

Senator **Durenberger**. Thank you very much, Mr. Bromberg. I appreciate your testimony.

Mr. **Bromberg**. Thank you.

Senator **Durenberger**. Our next two witnesses represent the Association of American Medical Colleges, Dr. John Cooper and Dr. Mitchell T. Rabkin.

I don't believe either of you are strangers to this issue, and I appreciate seeing you here. I welcome your testimony.

If you have prepared statements they will be made part of the record without objection, and you may abbreviate them or do anything you want within the 10-minute time limit.

STATEMENT OF DR. MITCHELL RABKIN, PRESIDENT, BETH ISRAEL HOSPITAL, BOSTON, MASS., ACCOMPANIED BY DR. JOHN A. D. COOPER, PRESIDENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. **Rabkin**. Thank you, Mr. Chairman.

I am Dr. Mitchell Rabkin, immediate past chairman of the Council of Teaching Hospitals, and president of Boston's Beth Israel Hospital, a 452-bed major teaching hospital of Harvard Medical School. I am accompanied this morning by Dr. John A. D. Cooper, president of the Association of American Medical Colleges.

In addition to representing all of the nation's medical schools and 73 academic societies, the Association's Council of Teaching Hospitals represents 329 State, municipal, and private not-for-profit hospitals. In 1980, hospitals belonging to the AAMC admitted over 1.5 million medicare patients and provided them more than 19 million days of care. Major outpatient and emergency service was also provided to medicare patients. Because they often have more serious illnesses, require greater use of resources, and generally stay longer than younger patients, medicare patients, while 18 percent of admissions, account for over 28 percent of total hospital revenue in COTH hospitals. As a result, major changes in medicare policies for hospital services are a vital concern of the Association and its members.

The Association's written testimony identifies numerous AAMC concerns with the HHS proposal, and offers a series of constructive recommendations for its improvement. We would ask that it be included in the record, but rather than discuss those technical items I would like to address five broad policy concerns:

First, crucial details are lacking. Despite its 220 pages, the Department's propective payment report is not complete. Many crucial details necessary to evaluate the proposal are not described: the pass-through computations, the payment for outliers or atypical cases, the procedure for determining indirect medical education costs, the methodology for updating historical data to reflect inflation are not detailed. The report also lacks the information for an individual hospital or group of hospitals to estimate fully the revenue impacts of the proposed system. If a legislative proposal more fully detailing the plan is submitted to Congress, the AAMC requests an opportunity to appear once again before this subcommittee.

Second, methodology cannot overcome inadequate funding. Much of the discussion already generated by the proposal is essentially a methodological critique or a defense of the approach. As important as these discussions may be on units of payments, base period, case mix measures, and standardization techniques are, let me emphasize that a medicare payment system is not simply a technical issue. A medicare payment system is a normative statement of the Government's values. Major issues, therefore, are questions of equity, incentives, opportunities, and constraints. When all the technical rhetoric is removed, a change in the medicare payment system is really a discussion of hospital supply, patient access, technological adaptation, and quality of care. It is the rate paid by the Government, and not the technical computations underlying it that dictates the ability of hospitals to serve our elderly citizens.

Third, statistical averages mask appropriate individual differences. The association is concerned with the report's repeated statements that "on the average" the statistical formulas are reasonable and the repeated assumption that the statistician's "law of large numbers" provides protection against adverse hospital impacts. Of the almost 6,000 community hospitals in our Nation, only about 6 percent are major teaching hospitals. While DHHS and HCFA may feel relieved that perhaps 90 percent of all hospitals are treated reasonably by the proposal, teaching hospitals are concerned that they constitute the bulk of the minority adversely impacted. Several characteristics of the Secretary's report suggest that teaching hospitals may be the most adversely affected because of their special characteristics and contributions.

For example, the HHS proposal makes no attempt to recognize differences in hospital operating costs growing out of differences in hospital size and scope of service.

Second, the newly formulated 1981 diagnosis related groups (DRG's) do not explicitly recognize differences in the severity of illness for patients within a diagnostic grouping. Thus, they do not take into account differences in the intensity of services which must be provided to the spectrum of patients within the same DRG.

With note to your question, Senator Durenberger, HHS does not have adequate information on patients to classify them into DRG's, because the 1982 DRG's were constructed under the assumption that all diagnoses and procedures must be considered to assess the patient's use of hospital resources, but HCFA's MEDPAR data, however, contains only the principal diagnosis or procedure, and the presence or absence of secondary diagnoses and procedures. And thus, a complete description of the patient's medical condition is simply not available, nor is it used in classification.

Furthermore, the methodology for estimating the cost of an individual patient's care tends to understate the cost of tertiary care and overstate the cost of routine care.

And the procedure for classifying cases understates the cost of patients with complicating conditions and overstates the cost of patients listed as having no complications.

Each of these concerns requires modification of the proposal if teaching hospitals, which tend to sequester the more complex cases, are to be paid fairly for the services they provide.

Fourth, teaching hospitals do more and cost more. It must be recognized that teaching hospitals do have higher average costs than nonteaching hospitals. Without attempting to define or defend every dollar of that difference, I would like to emphasize that for these additional costs, additional products are produced: Medical, nursing, and allied health students are trained, true; but in addition, medical science is advanced and refined, new and more effective techologies are introduced into medical care, better modalities of care are developed, and complex patient services are provided. It is inappropriate, sir, and even denigrating to assume, as does this proposal, that higher teaching costs not accounted for within the proposal's listed educational cost adjustments represent inefficiency, waste, and poor management. Those are diagnoses by exclusion, and we object to that.

Fifth, the proposal threatens hospital-physician relationships. The goal of the HHS proposal is to set a reasonable hospital price for a reasonable hospital product. Yet look at the thrust of its incentives: Hospitals must become more concerned with the cost of their individual units of services; hospitals must become more conscious of the payback period of new technology, but physicians must become more concerned with the financial consequences to the hospital of their admitting a patient; physicians must become more concerned with their use of ancillary services; physicians must become more concerned with the length of patient stays which they determine; and physicians will be moved to assess the advisability of establishing new technologies in their own offices, where payment is determined under the rules of Part B, rather than in hospitals paid on a prospective basis. Now, as this list of incentives is reviewed, it becomes clear that the prospective payment proposal addresses hospital services but focuses heavily upon physicians and their impacts on and relationships with hospitals.

As an association of hospitals and physicians, the AAMC is in a unique position to comment on a payment system which seeks to alter physican behavioral patterns by changing hospital payments. Relationships between hospitals and their medical staffs are delicate and highly individualized, having been developed at the most local level. The HHS proposal threatens to disrupt these relationships through an abrupt change in hospital payments. The AAMC believes that a more evolutionary change is preferable to the HHS proposal.

Therefore, the association strongly recommends moving to a prospective payment system, but one that determines payment on a perdischarge basis, by type of case, using an individual hospital's actual costs per case adjusted for inflation, as determined from the medicare cost report period immediately prior to the implementation of prospective payment. This approach allows hospitals to adapt, medical staff relationships to be redefined, and medical practice patterns to evolve in the desired direction.

A prospective payment system based on the individual hospital's historical cost for each type of case provides the best next evolutionary step in hospital payment. Such a system provides hospitals with an incentive to become more cost conscious and to temper costs; provides physicians with the incentive to evaluate carefully their practice patterns, yet it allows hospital/medical staff relationships to be redefined at a workable pace; it avoids the methodological and data limits inherent in the HHS proposal; it helps constrain Government expenditures for services provided for medicare patients; and finally, it would work to set a reasonable hospital price for a range of reasonable hospital products.

Thank you, and I would welcome any of your questions.

[The prepared statement of Dr. Rabkin follows:]

Statement on
Medicare Prospective Payment Proposal

Subcommittee on Health
Senate Finance Committee
February 2, 1983

Thank you Mr. Chairman.

I am Dr. Mitchell Rabkin, Immediate Past Chairman of the Council of Teaching Hospitals and President of Boston's Beth Israel Hospital, a 452 bed major teaching hospital of Harvard Medical School. I am accompanied this morning by Dr. John A.D. Cooper, President of the Association of American Medical Colleges.

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The Association's written testimony identifies numerous AAMC concerns with the HHS proposal and offers a series of constructive recommendations for its improvement. Rather than discuss those technical items, however, I would like to address five broad policy concerns.

First, Crucial Details are Lacking

Despite its 220 pages, the Department's prospective payment report is not complete. Many crucial details necessary to evaluate the proposal are not described, including the "pass through" computations, the payment for outliers or atypical cases, the procedure for determining indirect medical education costs, and the methodology for updating historical data to reflect inflation. The report also lacks the information necessary for an individual hospital or group of hospitals to estimate fully the revenue impacts of the proposed system. If a legislative proposal more fully detailing the plan is submitted to Congress, the AAMC requests an opportunity to appear once again before this subcommittee.

Second, Methodology Cannot Overcome Indadequate Funding

Much of the discussion already generated by the proposal is essentially a methodological critique or defense of the approach. As important as these discussions may be on units of payments, base period, case mix measures, and standardization techniques are, let me emphasize that a Medicare payment system is not simply a technical issue. We must not lose sight of the fact that a Medicare payment system is a normative statement of the government's values. Major issues, therefore, are questions of equity, incentives, opportunities, and constraints. When all the technical rhetoric is removed, a change in the Medicare payment system is really a discussion of hospital supply, patient access, technological adaptation, and quality of care. It is the rate paid by the government, and not the technical computations underlying it, that dictates the ability of hospitals to serve our elderly citizens.

Third, Statistical Averages Mask Appropriate Individual Differences

The Association is concerned with the report's repeated statements that "on average" the statistical formulas are reasonable and the repeated assumption that the statistician's "law of large numbers" provides protection against adverse hospital impacts. Of the almost 6,000 community hospitals in our nation, only about 6% are major teaching hospitals. While the Department of Health and Human Services and its HCFA component may feel relieved that perhaps 90% of all hospitals are treated reasonably by a proposal, teaching hospitals are concerned that they constitute the bulk of the minority adversely impacted. Several characteristics of the Secretary's report suggest that teaching hospitals may be the most adversely affected because of their special characteristics and contributions.

1. The HHS proposal makes no attempt to recognize differences in hospital operating costs growing out of differences in hospital size and scope of service.
2. The newly formulated, 1981 diagnosis related groups (DRGs) do not explicitly recognize differences in the severity of illness for patients within a diagnostic grouping. Thus, they do not take into account differences in the intensity of services which must be provided to the spectrum of patients within the same DRG.
3. HHS does not have adequate information on patients to classify them into DRGs because:

   o the 1982 DRGs were constructed under the assumption that all diagnoses and procedures must be considered to assess the patient's use of hospital resources, but

   o HCFA has data only on the principal diagnosis and procedure, and on the presence or absence of secondary diagnoses and procedures. Thus a complete description of the patient's medical condition is not available or used in classification.

4. The methodology for estimating the cost of an individual patient's care understates the cost of tertiary care and overstates the cost of routine care.
5. The procedure for classifying cases understates the cost of patients with complicating conditions and overstates the cost of patients listed as having no complications.

Each of these concerns requires modification of the proposal if teaching hospitals are to be paid fairly for the services they provide.

Fourth, Teaching Hospitals Do More and Cost More

It must be recognized that teaching hospitals have higher average costs than non-teaching hospitals. Without attempting to define or defend every dollar of the difference, I would like the members and staff of this subcommittee to know that I believe the teaching hospitals' higher costs are justified. For these additional costs, additional products are produced: medical, nursing, and allied health students are trained; medical science is advanced and refined; new and more effective technologies are introduced into medical care; better modalities of care are developed and complex patient services are provided. It is inappropriate and even denegrating to assume, as does this proposal, that higher teaching costs not accounted for within the proposal's listed educational cost adjustments represent inefficiency, waste, and poor management.

Fifth, the Proposal Threatens Hospital-hysician Relationships

The goal of the HHS proposal is to set a reasonable hospital price for a reasonable hospital product. Yet look at the thrust of its incentives:

- hospitals must become more concerned with the cost of their individual units of services,
- hospitals must become more conscious of the payback period of new technology,
- physicians must become concerned with the financial consequences to the hospital of their admitting a patient,
- physicians must become more concerned with their use of ancillary services,
- physicians must become more concerned with the length of patient stays which they determine, and
- physicians will be moved to assess the advisability of establishing new technologies in their own offices, where payment is determined under the rules of Part B, rather than in hospitals paid on a prospective basis.

As this list of incentives is reviewed, it becomes clear that the prospective payment proposal addresses hospital services but focuses heavily on physicians and their impacts on and relationships with hospitals.

As an association of hospitals and physicians, the AAMC is in a unique position to comment upon a payment system which seeks to alter physician behavioral patterns by changing hospital payments. Relationships between hospitals and their medical staffs are often delicate and highly individualized, having been developed at the most local level. The HHS proposal threatens to disrupt these relationships through an abrupt change in hospital payments. The AAMC believes that a more evolutionary change is preferable to the HHS proposal.

Therefore, the Association strongly recommends moving to a prospective payment system, but one that determines payment on a per discharge basis, by type-of-case using an individual hospital's actual costs-per-case adjusted for inflation as determined from the Medicare cost report period immediately prior to the implementation of prospective payment. This approach allows hospitals to adapt, medical staff relationships to be redefined, and medical practice patterns to evolve in the desired direction.

A prospective payment system based on the individual hospital's historical cost for each type of case provides the best next evolutionary step in hospital payment. Such a system:

- provides hospitals with an incentive to become more cost conscious and to temper costs;
- provides physicians with the incentive to evaluate carefully practive patterns; yet
- allows hospital/medical staff relationships to be redefined at a workable pace;
- avoids the methodological and data limits inherent in the HHS proposal;
- helps constrain government expenditures for services provided to Medicare patients; and
- works to set a reasonable hospital price for a range of reasonable hospital products.

Thank you for your attention, I would welcome any questions.

Senator **Durenberger**. Thank you very much. That was not only an excellent statement but well timed.

Senator Heinz.

Senator **Heinz**. Thank you, Mr. Chairman.

As the chairman has said, you have made an excellent statement, and there is a lot of food for thought in it.

One of the things that you may have touched on—you went so fast that I am not sure I have assimilated everything, and I was out of the room briefly at the outset—is that it does seem that teaching hospitals often treat atypical cases, which may involve an extreme length of stay. I am not sure I heard what you recommended HHS do about that or what you would prefer to see HHS do about that.

Dr. **Rabkin**. The fundamental recommendation, Senator, was that the prospective payment be based upon the individual experience of the particular hospital and go from there.

There was no specific recommendation, in part because the method of dealing with the outliers, those cases with longer lengths of stay, was not really detailed in the Secretary's proposal.

Furthermore, that itself would not accommodate the other problem inherent in the DRG's, where, for example, the degree of disability and therefore resource requirement in the institution of let's say any patient with cancer would be dealt with on an average level, but teaching hospitals, for example, tend to accrue—just as the cancer hospitals, which were thought necessary to be excluded, tend to accrue—the more complex, more problemmatic patients.

Senator **Heinz**. Now, just so we have some idea of the scale we are talking about, it's my understanding that HHS estimates that outliers would account for about one-half of 1 percent of all medicare patients. What do you estimate the number of those types of patients may be for teaching hospitals?

Dr. **Rabkin**. I have no facts on that. I am sure it's higher, but I have no facts.

Senator **Heinz**. It would be helpful to try and get a few of those kinds of facts, so we have an idea of how big a problem it is that we are dealing with.

My one reaction, Mr. Chairman, to what you have said with respect to your particular solution, which is to have an experience rating system for hospitals, is that it may in fact raise the problem of building in the existing inefficiencies in the system into the new system.

One of the things we all want to do is, we want to try to squeeze out all the existing inefficiencies. I don't know of any hospitals—I don't have constructive actual knowledge that there is a specific hospital that is keeping people an extra day or two, but I have not doubt that there are some hospitals that are.

Dr. **Rabkin**. I suspect there is a spectrum in all of the different types of hospitals, Senator; that is, I would be willing to match my data at Beth Israel Hospital in Boston with anybody's around the country, and I think we'd give them a fair fight in terms of careful control of utilization and quality assessment issues, and so on.

I don't believe that the difference in the teaching hospital costs should be looked at as this report implies, as being inefficiency and being waste.

The problem, it seems to me, is just that. You remember the late Senator McCarthy; everything that didn't fall within his definition of democracy was, by definition, communism. And that's not really a constructive way to go at the problem.

Senator HEINZ. Do you mean there is no waste? Anybody who suggests that there is waste or inefficiency is a Communist? [Laughter.]

Dr. RABKIN. No; I'm not saying that at all. What I'm saying is that I think it's a question of the baby and the bath water. If the system of health care were not providing reasonable care of reasonable quality, if teaching hospitals were not doing their job in the way of innovation, then I think you would be justified in trying to clamp down. But at the moment I think there is reasonable evidence that we are delivering products that are more than the average, improving the health care technically and methodologically. And therefore, if you were to deal with us on the average, you would be rewarding some hospitals which have no reason to be rewarded, those on the lower end of the spectrum, and pulling down the innovators and people who are trying to——

Dr. COOPER. May I add a word here?

If you make a judgment about how efficient or inefficient a hospital is on the basis of what it costs to treat a given DRG, then you have made a false premise; because the DRG, in spite of what the Secretary said this morning, does not take into account the differences in the patients within a DRG. And teaching hospitals generally are the places whether either the patients come or are referred by other physicians when they are very complex patients. So they have not compared apples and apples, as the Secretary said, they have compared apples and oranges. And when you make those kinds of comparisons, it's not fair to make the accusation that the differences in cost are due to inefficiency; they are indeed due to different patients that are being treated.

Senator HEINZ. Thank you.

Senator DURENBERGER. Senator Baucus.

Senator BAUCUS. Dr. Cooper, could you help us by elaborating a little more on the data or the examples that show why teaching hospitals see more expensive kinds of patients than other hospitals?

Dr. RABKIN. On the data why those patients are costly?

Senator BAUCUS. Some examples or some data that show it, rather than just the statement.

Dr. RABKIN. We have some material that we would be happy to submit in the record, some studies of medicare patients in 24 teaching hospitals using a methodology of disease staging, for example.

CLASSIFICATION OF MEDICARE PATIENTS IN 24 TEACHING HOSPITALS USING DISEASE STAGING, FISCAL YEAR 1978

	Disease stage				
	0	1	2	3	4/5
Infective endocarditis:					
Discharges	0	104	27	53	97
Average length of stay		17.4	19.7	13.7	17.2
Average cost per case		$6,060	$4,234	$5,054	$12,854
Essential hypertension:					
Discharges	0	391	10	2290	93
Average length of stay		9.1	10.8	14.3	14.6
Average cost per case		$1,862	$1,395	$3,717	$5,923

Source: Association of American Medical Colleges.

Dr. COOPER. Maybe we ought to explain disease staging for them.

Dr. RABKIN. Disease staging is taking something that might fall within one DRG and looking at those who are less sick, and medium, and more sick, and so on, and looking at the relative costs.

For instance, in just something as simple as essential hypertension, which can vary in terms of the demands made on the institution tremendously from someone who requires very little care to someone who is very sick and requires lots of diagnostic workups, we have come up with average-cost-per-case in the less intensity of about $1,800 all the way up to $5,900; or in infective endocarditis, from $6,000 to $12,000.

Now, what Dr. Cooper referred to was that these patients, the difficult ones to treat, tend to be sequestered at the teaching hospitals.

If you take the DRG of chronic obstructive pulmonary disease, for example, there is a wide range of illness from someone with simply some chronic pulmonary disease who has an acute exacerbation—trouble coughing, maybe the possibility of pneumonia—and is in the hospital for a day or two and essentially gets cleared up and goes home, all the way to someone who is desperately ill and requires all sorts of attention—intravenous antibiotics, all sorts of respiratory therapy, and so on. It's the latter that tend to be referred to the teaching hospitals.

Just as the sole community provider that the Secretary was referring to has to have certain things because that is the only resource for 25 miles around, so teaching hospitals, in many respects, are sole community providers for the last-chance cases. And that's why essentially the same argument holds that it——

Senator BAUCUS. I understand the argument. The more we can have backup information, the more we are going to know the degree to which to make exception, or the degree to which to treat teaching hospitals differently.

Dr. RABKIN. Well that, you see, is why we feel that it is better to go on the basis of the hospital's past history, even taking into account Senator Heinz concern about inefficiency, than it is to render an average price, per se. You will throw out more of the baby than the bath water.

Dr. **Cooper**. I think the points that Dr. Rabkin made are very important. The study we did was an extensive study on 750,000 discharges of patients from teaching hospitals that are members of COTH, and we analyzed the data from 24 hospitals in some detail.

This disease-staging breakdown of DRG's really shows a progression of cost as the method identifies sicker and sicker and sicker patients.

Now, this disease staging is not available in any of the approaches used by HHS in the development of prospective payment. A single DRG for infective endocarditis would cover the whole panoply of patients high we have shown really vary by looking at the disease stage, vary broadly. And this is why we have been very concerned about the inadequacy of the present methods, including the DRG's which are proposed, in really evaluating how sick the patient is, how much care the patient needs, and what resources are consumed in the care of that patient.

Senator **Baucus**. How are physicians going to react to the general proposal? I understand on the 17th, physicians will be appearing before this committee. I have not yet heard from a physician. You two are physicians; what is your reaction to this?

Dr. **Rabkin**. I think the points made by Mr. Bromberg and myself are valid. It's going to be tough trying to socialize these fellows into it. And that's one of the inherent problems of all of this; that is, you are working on the hospitals, but you have a problem because half the team is not there.

Just as the Secretary mentioned earlier the public-private schizophrenia in trying to get a handle on this, the institution-individual physician, who are being reimbursed in two completely different ways, is another kind of schizophrenia. And I think it's going to depend sharply on institution by institution.

Seantor Baucus. Do you have a DRG for that one? [Laughter.]

Dr. **Rabkin**. Trouble.

Senator **Baucus**. Thank you very much.

Senator **Durenberger**. Gentlemen, I think all of us appreciate the uniqueness of the medical colleges and teaching hospitals in our country. I think we also appreciate the fact that, as you indicate in your statement, there are a variety of roles that you see being played by your institutions. Those include the role of education, the role of research and the development of new treatment modalities, and in many cases the charity role.

What we are talking about is recognition of the uniqueness of teaching centers and the need to maintain and support those centers. But the question is how we are going to afford to get there.

I'm sure if Senator Heinz were still here he could talk to you about his pacemaker hearing. There's no question that our medical colleges have brought us very substantial advances in cardiac treatments which have generated a whole new set of industries out there.

We have developed a wide variety of lifesaving techniques at a relatively high cost. That is not to say you should switch course and get off of research and development, it is only to say that as policymakers we need to figure out what is the best way to spend scarce resources and deal with the problem.

One question I have of you, based on your testimony, is the issue of the severity of illness. I need to know why it is that you feel we should use historical institution-based data to deal with that problem rather than developing some standard of measuring severity, so that we can apply it across the whole spectrum.

Dr. **Rabkin**. I don't think we said "either/or," Senator Durenberger. I don't think that standards for measuring severity are that well developed that we should assume that the present DRG system meets the need.

When an appropriate standard is developed, I think we would probably sign on, as well; however, there is one caveat, and that is, in addition, teaching hospitals are responsible for other kinds of developments which may not come about in severity measures, and I think these should be recognized.

For example, at Boston's Beth Israel Hospital we have a program of nursing called Primary Nursing—it was written up in the Sunday Times Magazine on the day after Christmas—that tends to use far more nurses with bachelor's degrees than many hospitals happen to have. Therefore, inherently though no more bodies, it is more expensive. The point is, however, it is uncovering insights and improvements in nursing which may very well work to rejuvenate a good bit of American nursing. Now, that's a contribution of that particular institution, but there are other contributions of that sort that also have to be taken into account.

So, no matter how detailed an intensity system may be, it seems to me that a recognition of certain characteristics of certain hospitals has got to allow for other aspects of innovation, as well.

Senator **Durenberger**. Recognizing the value of the innovative and unique services particular institutions provide, I still question the degree to which the ill in America should carry that burden.

When do we deal with the realities that we are trying to address—the high cost of illness, sickness, and disease treatment in America—by providing incentives for people to stay healthy and make wise choices about the treatment of their illness? And now at the same time, can we preserve an institutional setting which emphasizes the high value of education, the high value of research and development, and the high value of developing new approaches to the delivery of health care service?

We don't have time here this morning, because we're all going out to the parade, in the rain, presumably [Laughter]——

Senator **Durenberger** [continuing].—But at some point in time I think this subcommittee needs to know the direction that the association is headed in advising national, State, local, and private sector decisionmakers about the future of medical education and the future of medical research.

If you have specific recommendations over the next couple of weeks, as you see more detail develop and as we all see a bill, about how to better define that teaching or that educational component as a passthrough, we certainly would welcome your advice on that subject.

Dr. **Cooper**. May I make just one final point?

You know, there are only a few over a hundred of the academic medical centers, out of the 6,000 or 7,000 hospitals in this country.

They are a very small group, and they are very unique institutions that really are the anchor points of the medical care system in this country.

Second, if you look at the total costs that really can be assigned to research and development in the field of health out of the health expenditures of $230–$240 billion, we really are spending a very small fraction of the total cost of health care in R. & D.

Although at first the R. & D. may increase the cost of health care, ultimately—as I think Lou Thomas has pointed out in his pathway-to-technology approach—ultimately we get to the point of where we reduce health care costs. The old example is polio, where at first we developed iron lungs, ways to keep them alive, and the costs went up; then we developed a vaccine, and now the cost of polio is almost zero.

And if one looks at case after case of where savings have been brought about by the research, when you add up all the savings that came about, they more than make up for the additional costs of the halfway technologies.

So one really has to look at the big picture in order to really understand that the costs that are being borne by either the Federal Government or the patient are relatively small in terms of the total bill for health care.

Senator **Durenberger**. Thank you for your testimony.

[The prepared statement of Dr. Cooper follows:]

association of american medical colleges

TESTIMONY ON THE
DHHS PROSPECTIVE PAYMENT PROPOSAL

SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON FINANCE
FEBRUARY 2, 1983

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Medicare proposal submitted to Congress by Secretary Richard S. Schweiker which advocates prospectively determined hospital payments for Medicare patients. In addition to representing all of the nation's medical schools and 23 academic societies, the Association's Council of Teaching Hospitals (COTH) represents 329 state, municipal, and not-for-profit hospitals. These hospitals account for 18% of the Medicare admissions to non-federal short-stay hospitals. Because Medicare patients often have more serious illnesses than younger patients, frequently require above average nursing and personal care services, and generally stay longer than other patients, Medicare patients account for over 28% of total hospital revenue in COTH hospitals. As a result, dramatic changes in Medicare payment policies for hospital services are a vital concern of the Association and its members.

The members of the Association are aware of the significant concerns about the continued financial viability of the Medicare program that have induced Congress and the Administration to consider changes in the way in which hospitals are paid for the care of Medicare patients. However, in considering proposals for making these changes, Congress should evaluate the ability of the proposed systems to provide the necessary cost savings while:

- fairly recognizing the differences in services necessarily provided to patients with different types and severities of illness;
- not discriminating against an identifiable group of providers or sector of the hospital industry;
- providing incentives for both short and long term cost effective behavior;
- appreciating that differences in cost not accounted for by the formula ultimately chosen are not necessarily related to inefficiency but reflect real and important differences between hospitals;
- allowing grievance and redress procedures to counteract regulations which may have serious damaging consequences to patient care and hospitals; and
- fairly providing for implementation of the system.

This last point is particularly important when considering the changes contained in the HHS proposal. The method of implementation should reflect an understanding of the limitations of the data used in developing the system, provide for the time needed by the hospitals to alter their management behavior, and make provision for continued improvement of the proposed payment system.

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As you will note from our comments, the AAMC believes that the HHS proposal is deficient in addressing these points. Moreover, despite the 220 page length of the Secretary's report on prospective payment, the Association wishes to note that weaknesses in the report prevent a fully informed analysis. First, many of the necessary crucial details of the proposal are not developed in the proposal. For example, no information is included:

- on the procedure which will be used to trend forward data from the time of its collection to the time of its use in payments,
- on the specific procedure to be used to determine capital and direct medical education cost "pass throughs,"
- on the methodology to be used for computing the proposed "lump sum payment" for the indirect costs associated with intensity of medical education activity, or
- on the specific procedure to be used to pay hospitals for the atypically costly cases called "outliers."

Secondly, the report lacks the information necessary for an individual hospital to estimate fully the revenue impacts of the proposed system. Thirdly, the report fails to include an impact statement describing the financial consequences of the proposal on different types of hospitals. Because the HHS proposal is essentially a modification of the present Section 223 methodology, it can be assumed, at a minimum, from data in the September 30th Federal Register that the HHS proposal will most heavily impact hospitals in New England, the Great Lakes and upper midwest, and the west. It will also impact relatively large numbers of small urban and rural hospitals. Without additional HHS data, other disproportional impacts cannot be determined. The Association assumes these shortcomings will be ultimately addressed in a subsequent legislative proposal and requests an opportunity to appear once again before this Subcommittee when more detailed information is available.

AAMC POSITION

The proposal, as submitted, includes five design characteristics which are desirable, in principle, for prospective payment systems based on nationwide data comparisons:

1. The use of a "per case" unit of analysis and payment emphasizes that the decision to admit a patient is the primary determinant of utilization, minimizes incentives to increase units of service, and promotes examination of present diagnosis and treatment regimens.
2. The explicit recognition of patient case mix in determining payment recognizes, within the limits of the present methodology available, that hospitals are not homogeneous and allows year-to-year changes in the mix of patients to be immediately reflected in the amount of payment.
3. The inclusion of an area wage adjustment partially compensates hospitals for geographic differences in these costs.

4. The "pass through" of direct medical education costs and the lump-sum payment for indirect medical education costs provide some recognition of the added costs teaching hospitals incur in operating graduate medical education programs.

5. The "pass through" for capital costs recognizes that physical plant and major equipment expenses are primarily historical costs reflecting prior year decisions, prior interest rates, and former construction and supply costs.

In spite of these design characteristics and the Association's general advocacy of prospective payment, the AAMC does not believe that the methodologies and data advocated in the Secretary's report can be used without substantial risk to the financial stability of hospitals. Moreover, the report assumes that hospitals can add and omit services largely as a result of the economic incentives included in the payment system. This assumption fails to recognize that hospitals must meet their community roles and responsibilities for service, even when a necessary service is economically unattractive. Therefore, the AAMC strongly recommends that an initial, national prospective payment system:

- determine payments on a per discharge basis by type of case using an individual hospital's actual costs per case as determined from the Medicare cost report period completed immediately prior to the implementation of prospective payment.

A hospital-based, per type of case prospective payment system based on a hospital's own base year costs provides the best next evolutionary step in hospital payment. Such a system provides hospitals with an incentive to become more cost conscious; it provides physicians with an incentive to carefully evaluate present practice patterns. A hospital-based, per case prospective payment system provides these incentives without the inevitable detrimental consequences of the Secretary's proposal.

EVALUATION OF HHS PROPOSAL

In the balance of this testmony, the HHS prospective payment proposal is evaluated in light of nine prospective payment principles advocated by the AAMC. Criticisms of and concerns with the proposal are raised and recommendations are made, where possible, for changes and modifications.

PRINCIPLE 1: PROSPECTIVE PAYMENT SYSTEMS SHOULD FULLY RECOGNIZE THE IMPACT ON OPERATING COSTS OF THE HOSPITAL'S APPROVED SCOPE OF SERVICES, ITS PATIENT MIX, AND THE INTENSITY OF CARE REQUIRED.

AAMC Concerns

1. The HHS proposal makes no attempt to recognize differences in hospital operating costs arising from differences in hospital size and scope of service.

2. The newly formulated, 1981 diagnosis related groups (DRG's) do not explicitly recognize differences in illness severity within a diagnostic grouping. Thus, they do not recognize differences in the intensity of services which must be provided to patients within the same DRG.

3. HHS is unable to use properly the DRG's to classify patients because:

    - the 1982 DRG's were constructed under the assumption that all diagnoses and procedures must be considered to assess the patient's use of hospital resources, but

    - HCFA has data only on the principal diagnosis and procedure, and on the presence or absence of secondary diagnoses and procedures. Thus a complete description of the patient's medical condition is not available or used in classification.

4. The proposal's use of average costs and cost-to-charge ratios for estimating the cost of an individual patient's care understates the cost of tertiary care and overstates the cost of routine care.

5. The proposal's procedure for classifying cases understates the cost of patients with complicating conditions while overstating the cost of patients with no complications.

6. The methodology HHS proposes to establish per case prices, excludes ancillary services not billed through the hospital. Because different hospitals have had different arrangements for ancillary services, some hospitals may be more favorably treated by the rates than others.

7. The 1981 patient data which HCFA proposes using to set 1984 payments rates:

    - include substantial errors because hospitals had no incentive to provide accurate and complete diagnostic and procedural data,

    - rely on inconsistent intermediary practices for reporting and verifyng diagnostic and procedural classifications, and

    - fail to reflect changes in medical practice between 1981 and 1984.

8. The present proposal contains no information on how the atypically costly cases, called outliers, will be reimbursed. This is a vital issue for referral centers having, which relatively large volumes of atypically costly patients, would be seriously harmed by use of national averages.

AAMC Recommendations

1. In previously computing Medicare cost limits, HHS has grouped hospitals based on bed size and hospital location to provide greater assurance that similar hospitals are being compared and that real differences in hospital costs are not being ignored. Under its prospective payment proposal, HHS should continue to group hospitals in this way.

2. Consideration should be given to excluding from the per case payment overhead expenses which are unrelated to direct patient care such as utilities, plant maintenance, and security.

3. In order to insure that any national average cost per case and the cost weights are properly calculated, HHS should verify that there is consistent reporting of data between institutions, and make adjustments where necessary.

4. HCFA should immediately review the new uniform billing form approved last year to assure it will provide more complete and more comprehensive diagnostic and procedural information.

5. HHS should consider excluding from the prospective payment proposal special-care hospitals (e.g., cancer hospitals) that may attract more acutely ill patients than the average community hospital within each of the DRG's they treat.

6. In constructing the per case payment rates, HHS will amass substantial information on resource use patterns implicitly underlying per case rate. Publication of the following per case information would assist hospitals in evaluating present practice patterns and in preparing appeals:

   - the average length of stay in special care unit beds for each DRG,
   - the average length of stay in routine care unit beds for each DRG,
   - the average proportion of each DRG rate resulting from ancillary services,
   - the average proportion of each DRG rate resulting from laboratory services,
   - the average proportion of each DRG rate resulting from x-ray services, and
   - the charge, cost, or length-of-stay values used to exclude some patients as atypically expensive, i.e., outliers.

PRINCIPLE 2: PROSPECTIVE PAYMENT SYSTEMS SHOULD RECOGNIZE REGIONAL DIFFERENCES IN THE COSTS OF GOODS AND SERVICES PURCHASED BY HOSPITALS.

AAMC Concerns

1. The HHS proposal assumes uniform wage rates throughout an urban or rural area, while past HCFA research shows labor costs are higher in central-city than in suburban areas.

2. The HHS proposal uses a wage index adjustment which assumes each W-2 wage report is for a full-time employee. This assumption and the resulting index unfairly penalize those geographic areas having atypical numbers of part-time workers, atypically high

turnover, or relatively heavy use of registry nurses by understating the hospital's true cost of labor.

AAMC Recommendations

1. HCFA should immediately enter into a joint project with the Bureau of Labor Statistics to develop wage indices separating labor costs in the core cities of Standard Metropolitan Statistical Areas from those in surrounding suburbs.

2. HCFA should work with the Bureau of Labor Statistics to prepare wage indices based either on average hourly compensation rates or full-time-equivalent personnel.

PRINCIPLE 3: PROSPECTIVE PAYMENT SYSTEMS SHOULD CALCULATE OPERATING COSTS ON A "GOING CONCERN" BASIS WITH FULL RECOGNITION OF HOSPITAL CAPITAL REQUIREMENTS.

AAMC Concerns

1. While the payment proposal asserts that historical data used to set prices will be updated to reflect inflation, no constraints are imposed on the Secretary for defining allowable hospital inflation rates.

2. The HHS methodology assumes all Medicare patients fully pay deductibles and coinsurance. When Medicare patients fail to pay these required charges, the hospital should be able to claim reimbursement retrospectively for these amounts from the Medicare program.

AAMC Recommendations

1. An advisory board to the Secretary should be established to provide an impartial estimate of the increase in hospital input prices, assist the Secretary in evaluating alternatives during implementation, and study and report on any adverse consequences resulting from the new payment system.

2. Under the proposal, a hospital could receive substantially less revenue in the first prospective payment period for the same number and mix of patients admitted in the last retrospective payment year. The inclusion of a "grandfather clause" precluding total prospective payment revenue less than final year retrospective payment would lessen the threat of undermining the hospital's fiscal viability in the initial years.

3. Because a formula-based prospective payment system is dramatically different from past cost reimbursement, it may result in substantial windfalls and shortfalls for individual hospitals. A three-year implementation period which sets each hospital's payment per case as a blend of its own costs and the payment rate (e.g., 75% own/25% standard; 50% own/50% standard; 25% own/75% standard; 100% standard) would moderate early year excesses and short-falls.

PRINCIPLE 4: PROSPECTIVE PAYMENT SYSTEMS SHOULD RECOGNIZE PHYSICIAN COSTS FOR PERSONAL MEDICAL SERVICES AND FOR MEDICAL PROGRAM SUPERVISION AND ADMINISTRATION.

AAMC Concern

1. In some hospitals, significant hospital costs are incurred for salaried professional and technical staff paid on a fee-for-service basis in other hospitals. If costs in all hospitals are averaged to compute national case weights and average per discharge prices, hospitals will receive "windfalls" or penalties depending upon hospital/staff payment arrangements.

AAMC Recommendations

1. Hospital costs for physicians' providing medical care to individual patients should not be included in the prospective rate.

2. Physician compensation for medical program supervision and unit administration should be paid on a cost reimbursement basis rather than as part of the prospective rate.

PRINCIPLE 5: PROSPECTIVE PAYMENT SYSTEMS SHOULD RECOGNIZE COSTS RESULTING FROM MANPOWER TRAINING PROGRAMS WHICH ARE ACCREDITED BY AN APPROPRIATE ORGANIZATION. COSTS RECOGNIZED SHOULD INCLUDE THOSE FOR EDUCATIONAL INSTRUCTION AND SUPERVISION, STUDENT STIPENDS WHERE PROVIDED, PROGRAM SUPPORT AND INSTITUTIONAL OVERHEAD, AND THE DECREASED PRODUCTIVITY ACCOMPANYING TRAINING IN THE HOSPITAL SETTING.

AAMC Concerns

1. The HHS proposal contains no information on how the lump-sum payment for the indirect costs of medical education will be computed.

2. While nursing education costs have been removed from Section 223 limits, these costs are not removed from the prospective payment rate. Thus, hospitals with costs for nursing education programs are penalized for particpating in the programs.

AAMC Recommendations

1. The adjustment for the indirect costs associated with medical education should be computed as a percentage increase in the otherwise determined per case payment. As in the present Section 223 limits, the size of the percentage increase should be directly related to the number of residents per bed.

2. As in Section 223 limits, costs of nursing education should be treated in the same manner as those for medical education.

PRINCIPLE 6: PROSPECTIVE PAYMENT PLANS SHOULD RECOGNIZE THE PATIENT CARE COSTS ASSOCIATED WITH CLINICAL RESEARCH TO BRING ADVANCES IN BIOMEDICAL KNOWLEDGE TO THE IMPROVEMENT OF MEDICAL CARE.

AAMC Concerns

1. While grants and contracts for research projects generally provide the primary funding for the clinical research activity itself, grants and contracts generally do not pay for the patient care costs that would otherwise be incurred as a result of the patient's illness. The patient treated under an approved research protocol remains in the original DRG category despite his more intensive patient care requirements. Because research programs result in concentrating these patients in a limited number of hospitals, the distribution of high cost patients is constrained. Hospitals with large clinical research programs and unusually ill patients will be penalized by a payment system based on the average case.

2. The use of national averages per type of case rather than payment based on specific experiences of the individual hospital removes resources for innovation from those institutions which have demonstrated the motivation and capability to improve care, and distributes those resources to the hospitals which have not done so. This is contrary to the Secretary's stated intention to provide incentives for innovation (p. 35 of report).

AAMC Recommendation

1. The AAMC would be pleased to work with Subcommittee members and their staffs to develop an adjustment for the atypical intensity of care required for patients participating in approved research protocols.

PRINCIPLE 7: PROSPECTIVE PAYMENT SYSTEMS SHOULD RECOGNIZE INCREASED COSTS ACCOMPANYING THE USE OF NEW DIAGNOSTIC AND TREATMENT TECHNOLOGIES.

AAMC Concern

1. Unlike the present Section 223 and percentage increase limits, the HHS proposal includes no specific recognition of the costs of the new diagnostic and treatment technologies. While the report does say that payment can be modified to reflect "...new technology proven to be cost effective..." (p. 64), no mechanism is provided in the proposal to demonstrate the desirability of new technologies. The increasing importance of CT scanners demonstrates an excellent example of the way in which one can seriously misjudge the benefits of new technologies when focusing upon their costs.

AAMC Recommendation

1. The AAMC would be pleased to work with Subcommittee members and their staffs to develop an adjustment for hospital costs accompanying the introduction of new technologies and modalities of care.

PRINCIPLE 8: PROSPECTIVE PAYMENT SYSTEMS SHOULD PERMIT HOSPITALS TO CHARGE PATIENTS FOR THE DIFFERENCES BETWEEN THE PROGRAM'S PAYMENT AND THE POSTED CHARGES FOR SERVICES USED.

AAMC Concern

1. The HHS proposal prohibits billing the patient for more than the mandatory deductibles and copayments. As proposed, participation in the Medicare program is a one-sided contract. The Government would specify both the benefits that must be provided and the total price for them. Because most hospitals are general medical/surgical facilities caring for patients of all ages, it is virtually impossible for hospitals to withdraw from the Medicare program. As a result, the one-sided contract envisioned in the HHS proposal is coercive and permits both arbitrary and capricious pricing by the government.

AAMC Recommendation

1. To assure patients access to a hospital of their choice and to minimize shifting costs of Medicare patients to other payers, hospitals should be permitted to charge patients for the difference between the Medicare payment (including deductibles and copayments) and the posted charges for services received. Hospitals electing to bill patients should be required to inform patients of this billing policy prior to the patient's admission.

PRINCIPLE 9: PROSPECTIVE PAYMENT SYSTEMS SHOULD PROVIDE HOSPITALS WITH A STATUTORY RIGHT TO OBTAIN ADMINISTRATIVE AND JUDICIAL REVIEW OF PROGRAM POLICIES AND PAYMENT COMPUTATIONS.

AAMC Concerns

1. The HHS proposal includes no mention of any administrative appeals mechanism for addressing erroneous data or computations, atypical patient severity, or underutilized but necessary specialty services.

2. The HHS proposal specifically precludes judicial review of any aspect of the payment system.

AAMC Recommendations

1. At a minimum, hospitals with substantially atypical situations (e.g., seasonal fluctuations, catastrophic events) should be able to obtain administrative exceptions to the payment rates.

2. Because all formula-based approaches are limited by underlying assumptions, errors in input data, and weaknesses in the metholology, hospitals should be able to request administrative relief from an independent review board with functions similar to the GSA Board of Contract Appeals.

3. Because the proposal includes broad discretionary authority to the Secretary and imposes essentially a coerced contract on

hospitals, hospitals should be able to obtain judical review of agency decisions and actions.

CONCLUSION

While the AAMC recommends that the payment limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 be replaced with a prospective payment system for hospitals, the defects and weaknesses in the HHS proposal are serious, raise substantial questions of equity, and assume hospitals have essentially homogeneous products. Rather than ammending the HHS proposal to correct or limit its defects, this Committee is urged to develop a per discharge payment system based on a hospital's historical operating costs per case type with adjustments for changes in patient case mix and input prices.

Senator DURENBERGER. The hearing will be recessed until 1:30 this afternoon.

[Whereupon, at 12:07 p.m., the hearing was recessed.]

AFTERNOON SESSION

Senator DURENBERGER. The hearing will come to order. This the second half of today's hearing, and the first half of two hearings we intend to hold on the subject of the administration's proposal for prospective payment of hospitals under medicare.

This afternoon's witnesses include representatives of American Hospital Association; New York State; Maryland; the National Association of Public Hospitals; and the State of Michigan.

The first of the witnesses will be Mr. J. Alexander McMahon, the president, accompanied by Mr. Jack W. Owen, executive vice president, of the American Hospital Association, Chicago, Ill. We welcome you both. I thank you for the opportunity to address some of these issues with your membership on Monday. I could hear the rumbles in the audience. And on behalf of the subcommittee, we appreciate very much the leadership role that the American Hospital Association has played. You were in here about a year ago, I think, saying we had to move to prospective payment and that you would go to work on making some suggestions in that area. I know that you have some. And I am sure all of us who need to deal with the realities of changes appreciate the fact that those who are going to be most affected know the change must come, and are willing to help shape the change.

We welcome you today. And if you have remarks that are not going to be read in full, they will be made part of the record as though they were read in full.

STATEMENT OF MR. J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. McMAHON. Thank you, Mr. Chairman. As you noted a moment ago, I am Alex McMahon, the president of the American Hospital Association. And with me is Jack Owen, the executive vice president here in Washington.

We do have a statement, a statement that was prepared before the meeting of the house of delegates adjourned just an hour and a half ago. The rest of the time was spent negotiating the traffic situation in downtown Washington.

I am going to speak because the House did not act again on prospective payment, more to that side. And I'm sorry they are not in the prepared remarks. But I shall try to be brief, Mr. Chairman, and hit only the important issues.

There is, very clearly, in the hospital world today a concensus still on the need for a new system. Cost reimbursement has served its time. It worked well when the whole message was to expand. And whatever we spent we were paid for. But that is not the world today. Thus, a prospective price system, which changes incentives, must come about, and come about very quickly, Mr. Chairman. And the American Hospital Association is ready to assist in developing a workable plan.

We are quite well aware from your statement to our people on Monday where you come off. I want to explain very briefly why we have taken a somewhat different approach. But in the process, lay in the framework for constructive dialog ahead because we will have a system, perhaps, that doesn't match anything that is before you as yet.

The American Hospital Association's proposal approved today differs from some of your ideas, Mr. Chairman, and from the proposals sent up by the Department of Health and Human Services in a couple of important respects. We still, after some discussion this morning, came down on the side of an institution specific base.

There are several reasons why we did. Obviously, a move to a very different kind of system needs a transition. And the institution specific base, even if it were temporary, provides a good transitional move. We can then develop a stronger data base for an average.

The average concept, Mr. Chairman, assumes that low cost means efficiency, and high cost has some questions about efficiency. That's not the way we look at the world. the high cost hospitals, as we analyze them, have a different kind of case mix; they have a different kind of patient mix; and they have a different range of services. They have the teaching and research aspects. And an average price inadvertently or unintentionally can damage important parts of the hospital system in the United States.

Now I would say one thing, Mr. Chairman. That is not the unanimous decision of the American Hospital Association as revealed in the discussions we've had, and as revealed this morning. There are many that think an average price is better. A majority of the house of delegates came down after a good deal of debate on the institution specific side because of the two things that I have mentioned. A recognition that it's a smoother transitional period, and a recognition that we still don't know that low cost, high cost means efficiency, inefficiency. And many of the high cost institutions are important parts of not only the hospital world, but in the whole medical education, the whole medical world in the United States. But there are some who believe that an average would be fairer because of the treatment it affords to hospitals who have, for example, during the voluntary efforts done a different kind of job in containing costs. Thus, because of this split of the field, I don't want to represent that as I do the need for prospective payment as the unanimous one. But perhaps there will be room for compromise in the discussions that come.

A second important area is our recommendation that a prospective price proposal have a nonassignment assignment proposition. That means that the medicare program would make a payment for a beneficiary. And if the hospital concluded that that payment wouldn't meet its cost, then it would have an opportunity to charge the beneficiary after adequate notice.

Now this, Mr. Chairman, can change some patient incentives. Obviously, it is going to stimulate the beneficiary to look for a hospital that would take the assignment to minimize the involvement.

But not only that, Mr. Chairman, we believe it can protect the beneficiary. If the price that is set is inadequate in the opinion of an institution, it's got some very onerous decisions to make. Should it withdraw from the program? Should it shift the costs to other patients? Should it go out of business? Or will it be driven out of business? And none of those alternatives are very beneficial to the beneficiary.

And so, indeed, in this proposal, Mr. Chairman, the hospitals are merely asking for what the doctors have had all along.

Now, finally, we paid our respects in our proposal to a couple of things. We think it would be better to cover all services. That's the quickest route to the simplification of the cost report. If you cover inpatient but not outpatient, then you still have to go through a cost allocation process in order to find out the appropriate cost of those services not covered by a prospective price. We think that's important.

We think an appeal mechanism is extremely important because however we go, whatever kind of proposal is finally developed, there is going to be the need for exceptions, and appeals from those exceptions, and even appeal from the determination of the prices by the Secretary and the Department.

And, finally, we think it would be most appropriate to include a waiver so that any group of hospitals geographically based, based by ownership, voluntarily based that can develop a plan that will keep the cost where it would otherwise be should be given that flexibility to do so. As that flexibility is exercised, we may learn some things.

In conclusion, then, the move toward prospective payment, Mr. Chairman, is the key issue, and exceeds all others. It's time to move, and we will do all we can to help you strike a reasonable compromise between the competing interest that will change incentives, but that will bring us all out to where you all want us to be, which is a lower rate of increase in hospital costs in the years ahead.

Thank you, sir.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. McMahon follows:]

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STATEMENT OF J. ALEXANDER McMAHON
BEFORE THE COMMITTEE ON FINANCE
OF THE UNITED STATES SENATE
ON
MEDICARE PROSPECTIVE PAYMENT

February 2, 1983

Mr. Chairman, I am J. Alexander McMahon, President of the American Hospital Association. With me today is Jack W. Owen, Executive Vice President and Director of the Association's Washington office. AHA is the principal national organization of hospitals, with some 6,300 member institutions and more than 35,000 personal members. I am pleased to have this opportunity to testify on proposals for prospective payment for Medicare, and I commend you for your expeditious attention to this issue.

In my statement, I will first review the background which has led AHA to its support of prospective payment, then outline several principles which must underlay any prospective payment system for Medicare, and finally comment on the major conceptual elements of the system which the Department of Health and Human Services (HHS) described in its report to Congress in December.

BACKGROUND

AHA strongly supports the adoption of a prospective payment system for most hospital services under Medicare. Our support is the result of more than two years of careful study of the effects on hospitals of steadily worsening payment shortfalls under traditional retrospective cost-based reimbursement. In 1981, a working party of our Council on Finance concluded that the only viable, lasting payment strategy for the hospital field is to develop new, innovative prospective pricing approaches which balance financial risks and rewards, such that hospitals are adequately paid for efficient and effective management and are penalized for poor performance.

Accordingly, during last year's hearings on the Fiscal Year 1983 budget, I called for an end to short-range, narrowly focused tinkering with the Medicare reimbursement system, and committed AHA to work with Congress on long-range structural reform of the incentives which confront hospitals, other providers of health care, and consumers. We followed through on that commitment by proposing an interim prospective payment system, based on average per-discharge payments. Our proposal was designed to implement the first stages of a full prospective payment system, while addressing the clear consensus in Congress for short-term federal savings.

While Congress did not enact our proposal, it did incorporate some elements of prospective payment in the Tax Equity and Fiscal Responsibility Act (TEFRA), P.L.97-248. The target rate provides, for the first time in Medicare, a limited recognition of the principle that hospitals which incur costs below a prospectively-determined amount can retain savings, rewarding performance in a manner similar to that used in the rest of the economy.

It is important to recognize that the Medicare hospital payment provisions in TEFRA were primarily intended as an expedient to meet short-range budget goals. Rather than lessening the need for Congress to act on a succeeding system, they greatly increase the importance of legislative action in 1983. If Congress allows true payment reform to languish until 1984 or later, then hospitals and other providers will be faced with having to accommodate the full three years of limits, which could cause significant financial dislocations for many hospitals, affecting the availability of care to many Medicare beneficiaries.

The expansion of the Section 223 limits to total costs per case, and the ratcheting down of these limits in FY's 1984 and 1985, will eclipse the beneficial incentives of the target rates for most hospitals. The Section 223 methodology, under which hospitals are grouped according to superficial similarities, provides no assurance that penalized hospitals are inefficient. A given hospital's Section 223 limit is determined less by its own cost behavior than by the behavior of other hospitals in its group, over which it has no control. Therefore, while the target rate is a step forward, it will be cancelled out by the Section 223 limits.

PRINCIPLES FOR PROSPECTIVE PAYMENT

This past autumn, after TEFRA had been enacted, AHA undertook an extensive review of its original proposal and the underlying principles for prospective payment. The working group which had drafted the proposal was reconvened and expanded to consider refinements. Its recommendations were considered at a series of regional meetings of hospital leaders across the country and by the regular policymaking bodies of the Association.

Although that process is not complete, a set of fundamental principles developed from these deliberations, which in our view must form the basis for a prospective payment system for Medicare hospital services. These principles include:

1) The system should balance the needs of government, providers, and beneficiaries, and establish consistent financial incentives for all parties to moderate the growth in Medicare spending over the long term.

2) The system should not be an instrument for arbitrary, short-term budget reductions.

3) A prospective payment system alone cannot overcome the negative impact on beneficiaries or providers of inadequate financing, or of counteracting demand incentives, under Medicare.

4) The system should provide a reasonable degree of financial predictability for the government, beneficiaries, and providers, so that the financial consequences of health care decisions can be known in advance.

5) The system should balance the financial risks for all parties.

6) The system must be sensitive to the case-mix of each hospital, so that hospitals are paid for the services actually provided.

7) The system should provide equitable payments, so that hospitals are not penalized for providing services to beneficiaries and so that well-managed hospitals can accumulate capital for modernization and appropriate expansion.

8) The system should provide incentives and adequate payment to hospitals for maintaining beneficiaries' choice and access to high quality services.

AHA is currently considering revisions of its original proposal, and shortly will be prepared to make specific recommendations. Let me emphasize that while AHA's recommendations may differ from the Administration's or other proposals, those differences are meant to be constructive contributions to Congress' development of a sound, workable system, and should not be viewed as impediments to action. We are prepared to move forward now, working with your committee and other committees in Congress and the Administration, to develop a mutually acceptable system. We believe this can be accomplished in this session.

THE HHS PROPOSAL

Although AHA has some concerns about the HHS proposal, we commend the Department, particularly Secretary Schweiker, for their commitment to adopting prospective payment in Medicare. This initiative, if it is carried out, will be a major contribution to strengthening the program in the years to come and to providing a catalyst for positive change in the entire health care system. We trust that Secretary-designate Heckler will pursue this proposal with equal vigor and that the Administration will make this a priority for 1983.

Keeping in mind the principles outlined above, let me turn to the HHS proposal. What we know at this point is derived from the December report to Congress. Since knowledge of many of the details must await specific legislation, I will confine my comments today to the conceptual elements described in the report, and will follow up later with reaction to the legislative provisions.

Scope of Covered Services

The HHS proposal would apply to acute inpatient services, presumably leaving other hospital services under the current system.

We recommend that prospective payment be applied to all hospital services. Different units of payment, such as per diem or negotiated rates, could be used where per case is not appropriate. If nonacute services, such as rehabilitation and psychiatry, were left under the target rate and Section 223 limits, or other controls, then new calculations would have to be made, somehow comparing nonacute costs among hospitals, no doubt producing anomalous results. Moreover, the cost reporting and auditing burdens of the current system would, in large measure, remain, cancelling out a major administrative cost benefit of prospective payment.

Startup Date and Transition

The HHS proposal would begin as early as October 1, 1983. We believe this is a feasible date to begin a phased transition to the new system; however, the HHS report does not indicate how such a transition would occur.

The experience in New Jersey with Diagnosis Related Groups (DRGs) should be instructive. Two types of problems were faced in implementing their experimental system. First, hospitals and government needed to be protected from sudden changes in revenue and outlay. Second, some hospitals did not have the data collection and processing capability on hand to adapt to the new system.

This experience suggests that hospitals without adequate data capability (e.g., some small hospitals and publicly-owned institutions) should have time to acquire the management systems needed before having to join the new system.

Data Needs

Hospitals' experience in New Jersey with DRGs, and nationally with the target rate and Section 223 limits, demonstrate the critical importance of integrating accurate patient care data with current financial data--a linkage which has not been required in Medicare in the past.

HHS proposes to use the MEDPAR data base and three-year-old cost reports to establish the DRG payment rates. We recognize that currently this is the only practical approach, but we have serious concerns over the accuracy of the MEDPAR data on a hospital-by-hospital basis, and over the validity of using old financial data updated by an arbitrary inflation index.

We recommend that current data bases be used to set initial rates, and that HHS undertake an intensive effort to upgrade its data collection and processing capability, so that DRG rates can be adjusted in future years to reflect accurate patient care and financial information in each hospital. As a first step, HHS should make available to hospitals the MEDPAR data base, so that its accuracy can be verified. Congress should mandate that all data used in calculating prospective payment rates be available to hospitals without delay.

Payment Unit

We are in the final stages of formally adopting a position on the use of DRGs and will be able to provide the committee with specific reactions in a few days.

Let me reiterate that an important principle for any prospective payment system is that it be sensitive to the case-mix in each hospital, so that payments are made with an accurate reflection of the resources used in providing Medicare services.

Adjustments to Payment Amounts

The HHS proposal provides that the Secretary may adjust the payment amounts periodically to reflect inflation and new technology costs. While we certainly agree that such adjustments must be made, we believe that they should be done on a regularly scheduled basis, with the formula specified in law and calculated by a technical body that is independent of HHS and capable of providing an objective adjustment.

Similarly, the proposal would permit the Secretary to adjust DRG weights to reflect changes in medical patterns of practice and resources used in providing services. Again, we certainly agree that such updating is necessary, but we recommend that a fixed schedule be established, for example every three to five years for each DRG, with the re-evaluation done by an independent technical panel.

The HHS proposal also would "pass through" capital and direct teaching costs. We agree that such costs must be fully recognized in each hospital's payments, and that pass-throughs are a practical method of recognizing these costs in the initial years of prospective payment. Ultimately, we hope that payment amounts would be equitable, permitting capital costs to be subsumed within the total price itself. The fundamental point is, however, that teaching hospitals must be able to finance their teaching programs and that all hospitals must be able to accumulate capital for replacement, modernization, and expansion to meet growth and change in demand for services.

Exceptions and Appeals

The HHS proposal would permit only one basis for exceptions--designation of a hospital as a sole community provider. Moreover, it would preclude judicial review of payments.

We believe that exceptions must be allowed on other grounds, such as circumstances beyond a hospital's control, so that individual institutions may obtain appropriate adjustment in their payments. Decisions on exceptions should be made by a panel that is independent of HHS, to insure objectivity. Both HHS and hospitals should have access to federal courts to adjudicate disputes over the system and obtain relief. These mechanisms constitute an important check and balance.

Waivers

The HHS proposal apparently would not permit waivers for alternative systems. We believe that waivers not only should be permitted, but also that they should be encouraged. Waivered systems provide the source of experimentation and innovation which can strengthen the program. A given national payment system should not be taken as perfect. New ideas should be encouraged and tested, so that the program can evolve and adapt.

Assignment/Nonassignment

The HHS proposal would require hospitals to accept the payment amount as payment in full, and would prohibit hospitals from charging beneficiaries amounts beyond the copayments and deductibles.

We believe that hospitals must be given an option of "nonassignment," that is, to be able to charge beneficiaries amounts beyond the Medicare payment. This option is necessary to permit some hospitals from incurring financial losses resulting from their participation in Medicare.

While we understand that this is a difficult concept for many to accept, Congress must begin to recognize that Medicare is changing inexorably from an open-ended program to one with financial limits. Also, other payers are now vigorously resisting the shifting of Medicare payment shortfalls, removing the traditonal method for absorbing financial losses due to Medicare payment limits. These trends make it inevitable that Medicare beneficiaries must accept more of the payment burdens for services that are more costly than the government is willing to finance.

Many hospitals will choose to accept assignment. Community attitudes toward assignment would heavily influence hospital administrators' and trustees' decisions, as would beneficiaries' subsequent use of nonassignment hospitals. In this regard, nonassignment is an important stimulus to competition; nonassignment institutions would have to compete with assignment hospitals for Medicare patients, and beneficiaries could choose between institutions on the basis of assignment as well as service mix and amenities. Beneficiary incentives must be consistent with the incentives for hospitals, if the federal government is to moderate the growth in Medicare spending.

SUMMARY

Mr. Chairman, we believe that Congress should enact a prospective payment system for Medicare hospital services. The first step was taken last year in the target rate provision of TEFRA, but the Section 223 limits will eclipse those positive incentives unless Congress acts this year.

Certain basic principles should form the foundation for prospective payment, so that consistent incentives apply to government, hospitals, and beneficiaries for long-range progress toward more cost-efficient behavior. We believe that prospective payment can be enacted in 1983 and we are prepared to move forward with Congress and the Administration in developing a mutually acceptable system.

Senator Durenberger. On the issue of assignment, I can see the value of it if we were dealing in a little more realistic world. For example, with the purchase of automobiles or something like that it makes a little more sense to talk about consumer involvement than it does with a beneficiary in selecting the most appropriate hospital care. It doesn't seem to me we are in that real world today. Beneficiaries, even where they are furnished with published rates as they are, for example, in my community, are really in no position at this point to do much other than to ask their doctors the next time they see them why they are suggesting admission to the high-cost hospital. It is still the doctors who are making the decisions, which is one of the reasons, of course, that we decided in TEFRA to implement a voluntary voucher system.

Most people put a cost sharing face on the issue of assignment. Is there any merit to the suggestion that in today's world people will make decisions between hospitals on the basis of charges?

Mr. McMahon. It would be better if we had had some broader experience because we haven't under the program. We certainly think so. And we see it in the rest of the world. The movement toward preferred provider organizations or HMO's or different kinds of modalities where there is a difference in the total impact on the beneficiaries gives us strong faith in the fact that people will become more cost conscious. And as I said, not only is there that, but what happens if the institution to which the individual relates finds because of the impossibility of bringing cost to the price that it can no longer take care of those individuals?

I'm thoroughly aware of the fact this is not going to meet with broad scaled enthusiasm in some quarters, but I take, and we take, Mr. Chairman, the opportunity to point out that the alternatives are onerous, too.

Senator Durenberger. The first argument that your majority makes in favor of the institutional approach rather than the averaging approach, is transition. There might be other ways, I suppose, to approach the whole issue of transition. Everyone is in a tough year right now trying to adjust to those TEFRA changes with target rates and 223. Are there alternatives to the institution-by-institution approach when it comes to a transition?

Mr. McMahon. Several, Mr. Chairman, recognizing the fact that our institutional specific approach may not apply. A question about what do you do if you go to an average price for small and rural hospitals where there are some real problems of fluctuations in case load and patient load. And in our discussions, they came to the conclusion that probably a small and rural hospital, under 100 beds, outside an SMSA, ought to have the opportunity to remain under the present system with its crew-downs that go along with it for perhaps a couple of years.

Second, we heard from the rehabilitation people to somewhat the same kind of problem. A specially rehab hospital made the—may be in one circumstance the rehab unit of an acute hospital. Again, you come to the conflict of the inclusion of all services to simplify reporting versus special treatment.

And, of course, we come finally to that most important segment—the teaching hospitals, the inner city hospitals, hospitals with high medicare volumes, hospitals with high volumes of low income patients. If we are going to move to an average—and we are not ready to respond to that yet because we still think the institution specific way is the preferable way to go to deal with those problems. On the other hand, the officers and I were given directions to take a look at ways that, again, within the total construct of what money you have available. None of these things are designed to ask for anymore money to see how we might accommodate those different kinds of institutions.

Senator **Durenberger**. Thank you.

Let me welcome a new member to the Finance Committee. A distinguished Senator from Arkansas, Dave Pryor. Dave, do you have any questions or comments?

Senator **Pryor**. The new member knows so little that I would embarrass myself and the committee by asking questions this morning. Thank you. I think I will refrain.

Mr. **McMahon**. I trust that embarrassment won't continue for very long. If we can help even quietly in an orientation, that's part of our job, too.

Senator **Pryor**. Thank you.

Senator **Durenberger**. Senator Dole.

Senator **Dole**. It's not a requirement to know anything here. [Laughter.]

If that were the case, our meetings would be much shorter.

As I understand, I think everybody is pretty much in accord that we need to move, and I hope move rather quickly. You are suggesting a phase-in or are you ready to move all at once?

Mr. **McMahon**. Move all at once. My point, Senator Dole, was that an institution specific price looks, to us, as a better transitional move even if you want to look at it a couple of years and come to an average price. Because there are strong arguments. As Senator Durenberger told our people on Monday morning, there are strong arguments for an average price.

On the other hand, we don't think that all of the differences in the range of low cost to high cost can be accommodated on an average. The way we see it, what will happen is that an average will hit in the middle and you will have a wide range. That means, frankly, some winners on one side, and some losers on the other. But the losers are more likely to be those institutions involved in teaching and research, inner city care of the indigent, of low income people; people, when they get to the hospital, are sicker because they don't have the same kind of nurishment; they don't have the same kind of home to go to.

We are talking about going all at once. But one way that we might see whether an average would work would be to start off immediately with an institution specific price, but recognize that a data base may be able to show us ways to get to an average either regionally or either by class of hospitals somewhere down the line that would be better than the single average price that HHS has proposed.

All at once, sir.

Senator DOLE. I see a number of signs that we may be able to compromise some of the differences, as far as I have heard; that the witnesses have indicated. It's my hope, and I am certain I express the view of others on the committee, that we can do it very quickly. I testified this morning on the House side on the social security compromise. And, of course, there are some who would like to include prospective payment in the social security package. I don't, myself, think that is a very good idea. It seems to me we ought to stick to the Social Security Commission and the Commission's compromise, and we will have other opportunities to do this.

But it is in our interest to move very quickly. And I think that's why the chairman is having the hearings today and tomorrow. We hope to have legislation ready to go very soon, and will try to work out the problems you may have and others have expressed because I think it is in our interest to do it and do it now.

Mr. OWEN. Senator Dole, if I could just comment on that for a second. I think you have to also be careful with small hospitals that may not have the computer capabilities to move into it quite as fast. And you might have to look at it from the standpoint that there might be a longer phase-in for that reason because of the capabilities of the smaller hospitals.

Senator DOLE. We have expressed concerns this morning—Senator Baucus, myself and others—in reference to rural hospitals, smaller hospitals, isolated hospitals, hospitals that serve primarily indigent patients—what do you do about new institutions? You may have covered all of this in your statement, which I haven't had a chance to look at. But we are going to, I say as chairman of the committee, move rather quickly on this if we can.

Mr. MCMAHON. We would be glad to see that.

Senator DOLE. As I listen to you, Mr. McMahon, you don't have any real hangups. There are a couple of areas where you have rather strong differences.

Mr. MCMAHON. Yes.

Senator DOLE. One is billing patients for any excess. Is that correct?

Mr. MCMAHON. Yes.

Senator DOLE. You are saying you should have the same rights that physicians have. We might be able to change that provision, and then you would have the same rights. [Laughter.]

Mr. MCMAHON. The important thing there, Mr. Chairman, and Senator Dole, is the fact that if there isn't that, what happens to a hospital who for one reason or another cannot bring its costs down? It's got some very, very difficult choices. And there are some advantages therefore to the beneficiary. We think that that, too, will work as a better transition. Because Jack Owen was involved in New Jersey on that transitional side, it might be useful to hear from him on some of the problems in moving very quickly into what is basically a different system.

Mr. OWEN. Just to comment on the billing of the patients, one thing you have to keep in mind is that each DRG will be a different rate so that there could be a hospital that had maybe 200 diagnoses in that hospital that would not require billing, and maybe only 100 would. You are doing it to a whole different system than just an average per diem. And I think this is an opportunity to work with the public as well to get them to start to look at which are the more efficient. You may find that one hospital can offer an appendectomy at a price that is acceptable to Government price, where another cannot.

And I realize, as Senator Durenberger says, that sometimes you have to talk to your doctor first before that happens. But I think we will see those changes take place.

If I could just make a couple of comments to Alex's concern about going too fast on some of this. There are some interesting questions that we will still have with HHS. I don't think they are so difficult that they can't be worked out, but such things as the outliers. We don't know quite yet how they are going to pay for those. Are you going to go on a basis of a charge, which would make sense? But there will be outliers. There are those problems that we refer to as "trim point" problems. Those who fall on the outer edges of DRG. Somebody just going in for a few hours, and getting transferred to another hospital. Do both hospitals get the benefit of that? How will that be handled?

These are problems that will crop up, along with the problems of proper coding. There are a lot of questions about, well, the physicians have been taking care of patients for years, and they really didn't care how they listed those diagnoses as appeared on the record because it wasn't important. Now it is important. And you find out that you have to go back and correct errors and look at those files. There needs to be some time for that transition.

So we would very much like to see this thing move very quickly because we think it is the right way to go. But keep in mind that there will be some transition problems that we are going to have.

Senator DURENBERGER. Thank you. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Why, in your view, do eastern seaboard hospitals have greater lengths of stay?

Mr. MCMAHON. I have no idea. None of us have any idea about it. It appears that this is episodic again. You can send an eastern doctor west and he changes his practice patterns; and send a western doctor east and he changes his. We don't know. It seems to be the way doctors react in a peer setting. It's a different kind of practice of medicine. We can't identify climate as being different. It certainly doesn't have anything to do with the number of beds. Maybe it's habit patterns. But perhaps when the AMA people are here they can answer it. We can't find out.

Senator BAUCUS. Is there any study or any indication that eastern seaboard patients receive better care because the length of stay is longer?

Mr. MCMAHON. We don't see any difference in outcomes.

Senator BAUCUS. The outcome is the same basically?

Mr. MCMAHON. It seems to be. Health status or whatever.

Senator BAUCUS. And does that indicate to you that those lengths of stay are too long in the eastern seaboard compared to the others?

Mr. McMahon. I'm a layman on this side of this issue. I'm going to put myself in the hands of a physician. And if he says this is what he thinks is good practice, I'm not sure I want to substitute my judgment for his. I do think, Senator, that the idea of a price for admission has got incentives for it. To take a look at the length of stay for each patient and then go after some of them and find out how things are done. By the same token, an average price, as the westerners have been pointing out to us—an average price is better from the western point of view because they say we've got less room to move to shorten length of stay than the easterners do. And this is—at least we have got all these issues up on the table. So the idea of a price per case, price per admission, is a better way, it seems to us, to incentivize people to look at the length of stay and see what might be done.

Now if we were to mandate, if we were to tell them what to do, we are not going to do nearly as well, we think, as to change incentives.

Senator Baucus. Under the definition of rural hospital, you come up with, what, 100 beds or 50 beds? I ask the question because as I look at the experience with section 223, there seems to be more of a natural break with the 50-bed level rather than the 100 bed. I'm curious whether your analysis indicates that 100 beds——

Mr. McMahon. That's got a lot of constituents between the 50 bed and the 100 bed. [Laughter.]

For the same reason.

Senator Baucus. I've got a lot of constituents 50 and lower. [Laughter.]

Mr. McMahon. It seems more to go to this point. That we don't think there is anything magic about 50. Of course, there is nothing magic about 100 either. But even in an institution of 75 or 80 beds, there are going to be fluctuations in occupancy; there is a greater impact with the gain or a loss of a physician on the medical staff. And as we looked at it, it seemed that hospitals between 50 and 100 are more like hospitals from 25 to 50 than they are from 100 up. And that's the reason we came to the 100 bed conclusion.

Senator Baucus. Why doesn't the American Hospital Association support peer review?

Mr. McMahon. We do. We always have. And the closer it is to the institutional level, the better.

Senator Baucus. Well, I hope we have your support aggressively on that because, as you know, the Administration has proposed to phase it out.

Mr. McMahon. Yeah, the concept certainly does. The AMA published a peer review manual long before the PSRO's developed. The American Hospital Association published a quality assurance manual to encourage physicians in the medical staff of a hospital to work together with one another to assure quality and make sure that what was going on was right. When the PSRO legislation in 1972 came along, the worse thing that I think happened was it became a paper-shuffling operation instead of a statistical operation to look at the physicians that were on the extreme. And that was the problem. It just didn't approach quality assurance appropriately.

Senator Baucus. So the association, then, opposes PSRO's? Is that right?

Mr. McMahon. The history we had with PSRO's didn't show that it was useful at all. There are better ways of doing it.

Senator Baucus. We all worry about potential problems with prospective reimbursement. The DRG methodology and others have been mentioned. And we all, I think, on this committee are not certain that the DRG methodology will be adequate. It may be that some kind of beefed-up peer review system will serve as a way to handle some of the problems we see with DRG's. But I hope that your association looks hard and long at ways to make sure we find out ways to stop DRG creep and unnecessary admissions—and to promote quality of cave.

Mr. McMahon. Our proposal addresses that directly by urging a provision for hospital deem status, for hospitals that could prove to the intermediary panel of physicians, even a peer review operation, that the medical staff knew what it was doing, and was providing those necessary safeguards on all sides.

Senator Durenberger. I think, Alex, it was the American Medical Association that, by four or five votes, was opposed to peer review. And then down in Florida a month or so ago changed their mind. And now they are not so sure they should have changed their mind because, without adequate financial backing from the administration for adequate peer review, they are getting some less than satisfactory recommendations from HHS on how to do it realistically, which was what we were trying to do.

Does anyone else have any questions of Mr. McMahon?

Senator Pryor. If I may. Is the New Jersey situation the only State or only conditional environment where we have had sort of a pilot program on this new concept or was that, in fact, a pilot program?

Mr. Owen. Well, the New Jersey—what started out as a waiver, a pilot, it was a pilot for several years and then it became part of the State law. Maryland has a system called GIR, which uses a DRG-driven mechanism.

You have to be careful, though, when you are thinking about the New Jersey situation as it relates to this one because there is a difference. And the difference, the basic one, is that the ratemaking must make a hospital solvent when they get through. Because in that rate they have got the loss of revenue for indigents and those other things.

Now we are talking about a program that just handles medicare only. And we are talking about only the costs that go with medicare. So you have a different kind of driving force. The other thing in the utilization aspect of it that Senator Baucus mentioned was that in the DRG there is utilization built in. In other words, the amount of resources that are needed for cases built into that DRG so there is not as much need for the kind of PSRO activity which has taken place. Whether the patient should be in there is one question. Once the patient is in, the price handles it.

But the DRG system mechanically has worked in New Jersey, and the same mechanics are being developed by the HHS. But the ratemaking part of it is different.

Senator PRYOR. Well, under the DRG proposal this is not exactly on the aspect of a pilot program. But under the proposal proposed by the Secretary, I think there are 460 different categories——

Mr. OWEN. 470.

Senator PRYOR. 470. And let's say that a hospital—let's say it was computer No. 290, and that was an appendectomy, a normal appendectomy with no complications. And just for example, let's say it was $700. Let's say they could do that for $500, and that's all the costs that are allocated for that. Now do they get to put the difference in their pockets, so to speak, or do they get to basically make that decision on their own? Is that a decision made on their own?

Mr. OWEN. Under a true prospective rate, what would happen is they would develop each DRG as sort of a bell curve. And they set the price in the center of that. And the idea is being that on one side of that bell curve, you will have a number of patients who will use more resources, and on the other side those who use less. And over a number of cases, it should average out to that $500 so that if one patient comes in, it might cost you $600, and the next one might be $400. But over a period of time, you have got to worry about the price of $500.

As Alex pointed out, if, in that bell curve, all of them are on the upper side, there is no way you are going to recoup. And that's the concern we have of keeping the patients completely out of it. Because the patient is going to want to go to that hospital even though the costs are higher because they selected that hospital. And the hospital is left in a position of either not participating or—

Senator PRYOR. All right. Let's say if we have a hospital or another institution that has to show a profit, and they get to the end of the year and the profit situation is looking pretty skimpy. And they see an opportunity to maybe cut back a little bit on that appendectomy. Maybe they will let the patient stay one night rather than two. Or maybe they will not feed them steak, but they will feed them oatmeal or whatever. Where do you think those savings, or where would be the tendency to shave the costs so that the profits are there?

Mr. OWEN. Well, in New Jersey I never witnessed anything that was a shaving that affected the quality of care. There were certainly questions raised by physicians of will it be four X-rays, or will three do it? Do you need five tests or will two do it? The food didn't seem to deteriorate. The section rate didn't go up. The mortality rate didn't go up. In some institutions, the length of stay went down.

Senator PRYOR. I see. Thank you.

Senator BAUCUS. Let me just follow up on that last line of questioning. What happens when the physicians says, "No, we need five X-rays"?

Mr. OWEN. This played an important role in this whole program and one of the things—in New Jersey—you will probably hear from New Jersey people later on—but in New Jersey, the physicians in the medical staff of a hospital looked at the data, and most of this will tell you that they know a physician who is very good in the institution. He doesn't do anything wrong, but he overutilizes.

And you don't kick them off the staff because he is a good physician. Now, all of a sudden, it is pointed out to him that Dr. Smith is costing this institution $200,000 or $300,000 a year. It's questionable whether we can reappoint him to staff on that basis. I mean we can't afford to have you, when all the other physicians doing the same kind of diagnoses, same kind of treatment, are not spending that kind of money.

And 9 times out of 10, the physician will say, "I didn't realize it." When they are doing taught medicine, they don't get courses in economics and so forth. It's just to take care of that patient. And in most cases, when the peer pressure confronts them, they will change their ways. And then it is up to that board to decide whether they want to continue losing money or whether they want to get rid of the physician.

Senator **Baucus**. So it's very possible that the hospital board will not fire a physician who practices at that hospital on the basis that he is costing the hospital too much?

Mr. **Owen**. The possibility exists. I don't think it would happen more than a rare case.

Mr. **McMahon**. The activity is more likely to come with the medical staff, because that medical staff is going to be thoroughly concerned about the financial viability of the institution that they rely on for their sickest and most injured patients. So the pressures start with the physicians.

I don't see this resulting in either administrative or trustee interference in the practice of medicine. I do think it brings to the practice of medicine a greater cost consciousness, a cost concern, to retain the viability of the institution.

Senator **Durenberger**. Any other questions?

[No response]

Senator **Durenberger**. Thank you very much, gentlemen. We appreciate your candor.

Our next witnesses are a panel consisting of Mr. Robert M. Crane, director of the Office of Health Systems Management, New York State Department of Health, Albany, N.Y., Mr. Charles F. Pierce, deputy commissioner of health, State of New Jersey, Trenton; and Dr. Hal Cohen, executive director, Maryland Health Services Cost Review Commission, Baltimore, Md.

Gentlemen, we welcome all of you. We commit your statements to the record without objection, and invite your summary of those statements.

We will go Cranc, Pierce, and Cohen, unless you have an alternative.

STATEMENT OF ROBERT M. CRANE, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, N.Y.

Mr. **Crane**. Thank you, Mr. Chairman. I am Robert M. Crane, Director of the Office of Health Systems Management of the New York State Department of Health. I would like to discuss New York State's cost containment efforts and how it has developed and pioneered a prospective hospital payment system over the last decade.

In January of 1983, this payment system was extended to all payers, including medicare, under a waiver approved by the Health Care Financing Administration. This waiver establishes a revenue cap for each hospital in New York State. New York pays hospitals on the basis of an all inclusive per diem rate, not a diagnostic related group per case rate as proposed by the Department of Health and Human Services.

However, diagnostic related groups and the related major diagnostic categories play a major part in our reimbursement methodology. New York establishes each hospital's case mix intensity, which is used in three different ways to determine a hospital rate.

First a DRG based case mix data is used to cluster hospitals in groups for comparison purposes, and the establishment of operational cost standards.

Second, each hospital's DRG complexity relative to his peers in this group is used to determine its individual allowable cost per day.

Finally, the length of stay standards applied to hospital costs are corrected for a facility's mix of patient types.

New York State is aware of the shortcomings of a per diem reimbursement methodology, some of which the committee has talked about earlier. Clearly, there is an incentive to lengthen a patient's stay. Similarly, we are aware of some of the advantages of a per case system of reimbursement that has the opposite incentive, although it clearly has an incentive to increase admissions. This the committee will need to consider carefully.

Nonetheless, after considering a variety of approaches to prospective payment, the system we have developed in the past, and the diagnostic related group per case system, we rejected a DRG system for several reasons.

First, a number of factors undermine the accuracy of the DRG structure. These include faulty reporting by hospitals and other data base problems, uncertainty between principal and secondary diagnosis, lack of social economic factors that might influence health status, and the use of average length of stay as a proxy for resource consumption.

Second, our case mix study, which we carried out in the late 1970s, found difficulty in DRG costing because of the noncomparability of hospital cost allocations, the difficulty in isolating teaching costs, and the lack of uniformity in hospital reporting.

Third, there was a concern about the unpredictability and fiscal consequences that might result from a shift from a per day system to a DRG system. Thus New York felt most comfortable given those reasons for a continuation of our own system.

I think as you have heard in the testimony earlier today, the problems attendant to a DRG system can be corrected and disincentives can be offset. We would encourage the committee to look at and move in the direction of establishing some sort of prospective reimbursement system.

Independent of the type of prospective system which you end up adopting, I would urge the committee to consider the three major issues.

First, an all-payer cost containment system should be considered as an alternative to a medicare only system. Our own experience in

New York State, in fact, has led us to the conclusion that an effective, cost containment program requires all payers to participate. Otherwise, the primary effect is simply cost shifting among third party payers. We started the system with medicare and Blue Cross only. We found hospitals rapidly rising their charges to a point where in some cases there is a 25- to 80-percent differential between charges for private payers and Blue Cross and medicare. I think this is a legitimate concern associated with the proposal that's before you.

Second, independent of whether Congress goes with the medicare only system or an across the board system, States should be encouraged to adopt all-payer systems and continue experimenting with payment methodologies. The Department of Health and Human Services now discourages this.

Certainly States that have demonstrated cost savings in the past should not have this experience held against them which has been the case with both Massachusetts and New York. In both cases, HCFA has granted statewide waivers with the condition that their medicare costs be kept 1½ percent below the national rate of increase. Presumably, this is the price for adopting an all-payer system. The reverse should actually be true. And we would encourage you to adopt provisions in this bill that would provide incentives, not penalties, for States to move in this direction.

Finally, our feeling is that any prospective reimbursement system should be complimented by a strong system of health planning. As you well know, the administration's proposal contains a pass through for capital, while at the same time advocating repeal of the health planning program.

The prospective system that is envisioned will do little to moderate rising capital costs. And, in fact, may even encourage hospitals to invest in order to attract patients under the DRG system.

We, in New York, are strong advocates of a rational health planning system. And we see it as a compliment to a prospective reimbursement system. We are now faced with major capital expenditures which, if passed through and without the check of a health planning system, would mean significant expenditures both for New York State, private insurers and for the Federal Government. New York will be faced with 5 billion dollars' worth of capital expenditures by 1984. If approved the burden that those expenditures will place on the medicare program is in the neighborhood of $6 billion over the lifespan of those projects.

We would encourage the committee to consider the capital question along with the operational cost limits themselves.

Thank you.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Mr. Crane follows:]

Testimony by Robert M. Crane, Director
Office of Health Systems Management
New York State Department of Health

Before the Senate Finance Committee
United States Senate
Washington, D.C.

On Prospective Hospital Reimbursement and
the Use of Diagnostic Related Groups (DRGs)

February 2, 1983

Mr. Chairman, members of the Senate Finance Committee, I am Robert M. Crane, Director of the New York State Office of Health Systems Management. I appreciate the opportunity to testify before you today because we in New York have been pioneering case mix efforts with diagnostic related groups (DRGs) since 1977. While New York State does not pay hospitals using a DRG per case reimbursement system, case mix measures have been an integral component of our hospital payment system for a number of years.

In December of 1977, the Health Care Financing Administration (HCFA) funded New York's Case Mix Study, a research project involving a representative sample of forty-one hospitals throughout New York State which had as its purpose the development of a methodology to measure the relationship between case mix and hospital costs. The choice of New York as a research and demonstration site was and is particularly relevant to the national hospital system:

- New York's 290 hospitals range in size from 20-bed community hospitals in isolated rural communities to 1,000-bed urban medical centers serving patients from all over the world. Yearly budgets exceed the gross national product of some nations.
- In New York, voluntary hospitals account for 75 percent of total hospital beds, proprietary hospitals 8 percent, and public hospitals 17 percent. Nationally, voluntary hospitals account for 70 percent of all hospital beds, proprietary hospitals 8 percent, and public hospitals 22 percent.
- New York has 3.9 beds per 1,000 population; nationally this figure is 4.5 beds per 1,000 population.

Indeed, New York's hospital industry not only mirrors the variety and the problems of hospitals throughout the nation, it also represents a major component of our country's medical resources:

- New York has 8 percent of the nation's hospital beds.
- New York's hospitals employ more than 10 percent of the nation's hospital workers.
- Hospital expenditures in New York account for 10 percent of the nation's hospital expenditures and a similar or greater percent of Medicare's expenditures for hospital care.
- New York has 15 percent of all teaching hospitals in the nation.

Finally, New York has been no stranger to the problems now confronting the nation--ensuring that quality health care services are provided to our citizens at a reasonable cost. Our State has been committed to a vigorous and successful cost containment program since the late-60's. As noted in the Deparment of Health and Human Services' December 1982 Report to Congress on Hospital Prospective Payment for Medicare, New York has had the best record of any State in the Nation in restraining hospital costs. Between 1975 and 1979, total hospital costs in this country increased by 64.5 percent while New York's hospitals increased at less than half that rate, 31 percent. Looking at a later period, 1977-1981, the national annual percent increases in cost per adjusted admissions averaged 13 percent. During that same period, costs in New York increased by only 9.78 percent. The application of case mix data to our cost containment efforts since 1976 has added credibility and ensured that the outcome has been reasonable and responsive to providers.

A prospective cost-based reimbursement formula for hospitals was first implemented in New York in 1969. Over the years we have evolved a payment program that has gone beyond that basic notion of merely containing inflation rates to one that incorporates financial incentives and controls aimed at three principles:

- Cost containment measures should not adversely affect actual patient care programs;
- Payment should be based only on care that is efficiently provided;
- Unnecessary services must be eliminated, or, at the very least, sharply reduced.

Until the past year the Public Health Law in New York required hospitals to be paid at rates related to the "efficient production of services". These efficiency standards have been defined by hospital peer group standards which, in turn, have evolved to a high degree of technical sophistication. By the mid-1970's both the State and the industry recognized that these standards must be applied to comparable hospital products. That is, the cost efficiency standards and norms must be adjusted for an institution's particular mix of patients.

The units of cost most frequently selected for cost comparisons are patient days and admissions. Neither of these units offer uniform measurement; changes in the type of care delivered and the severity of patient types admitted may have important consequences for hospital care.

A shared recognition of the need to explore the relationship between hospital costs, patient diagnoses and hospital patterns of treatment stimulated a cooperative effort between the New York State Department of Health and the Hospital Association of New York State that resulted in the federally funded Case Mix Study. We began applying by-products from the Study as early as 1978 to hospital reimbursement rates. In fact, case mix indices were used to adjust reimbursement appeals dating back to 1976. Since 1981 case mix or service intensity weights have been directly incorporated into hospital rates.

We are quite familiar with the advantages of paying hospitals according to an entire episode of care. DRG reimbursement can (i) reverse the incentive to prolong length of stays that are prevalent under a per diem system; (ii) reimburse the reasonable, total cost of a hospital stay while discouraging the provision of unnecessary ancillary services as in a system linked to charges; and (iii) reflect the resource requirements due to the specific mix of patients in a hospital.

Despite these merits, we in New York chose an alternative route as a result of the research from the Case Mix Study and a review of the pros and cons of a DRG rate system -- both activities carried out in conjunction with the hospital industry.

In New York State we reimburse hospitals on the basis of an all-inclusive per diem rate. Because of the size and complexity of New York's health care system, we use a formula-based methodology rather than a time-consuming budget review process.

New York has adopted the principle that the best way to measure a hospital's efficiency is to compare it to its peers. We developed a grouping methodology to compare similar hospitals using a variety of factors such as size, location, teaching versus non-teaching, average age of the hospital patients, case mix, and so on. We established reimbursement ceilings at slightly above the average routine and ancillary cost for each group--with facility-specific case mix adustments. In effect, this establishes the average cost as our basic standard for the efficient production of services. However, we permit any hospital with costs exceeding this standard to appeal based on a variety of factors.

We refined this system which has an incentive to lengthen stays by incorporating a system for disallowing the unnecessary cost of excessive patient length of stays. We also included in our rate methodology a system for disallowing the unnecesary costs incurred by hospitals with chronically low occupancy. Empty beds and expensive equipment lying unused for a large part of each day is another common cause of high unit costs and without a doubt, one of the least defensible. We developed a schedule of minimum utilization standards that took into account the type of service, e.g., medical/surgical, obstetric, and open heart surgery. Provisions are made for the special circumstances of isolated rural hospitals.

Hospitals are not reimbursed for the extra per diem cost when occupancy falls below these standards. This provision was not only effective in reducing expenditures, but it provided an incentive for consolidations, mergers, and closures.

A volume adjustment which is related to fixed and variable costs is used to reward hospitals for reducing patient hospitals days. We reimburse any hospital able to reduce patient days below a predetermined target approximately 80 percent of its per diem rate of payment for every day of care below the target that the hospital did not provide. Conversely, we reimburse any hospital unable to control patient days only 20 percent of its per diem rate of payment for every day of care provided above this target.

Each hospital's individual case mix intensity is used three ways in determining its rate under the New York system. First, DRG based case mix data are used to cluster hospitals into comparable groups for the purpose of establishing operational cost standards. Second, each hospital's DRG complexity relative to its peer group is then used to determine its individual allowable cost per day. Finally, the length of stay standards applied to hospital costs are corrected for a facility's mix of patient types. These same case mix standards apply under the recently approved all-payor system in New York.

These adjustments produce hospital rates which are essentially equivalent to DRG rates and overcome the inherent problems normally associated with per diem payments. On the other hand, using the case mix measures as adjustments to an all-inclusive rate overcomes many of the imprecision problems of the DRG specific rate such as classifying unusual cases and accurately pricing out diagnoses and is less likely to encourage "DRG creep" since hospital income is not as directly related to billed diagnosis.

Unfortunately, a number of factors undermine the accuracy of the DRG structure:

-- faulty reporting by hospitals;

-- confusion between principal and secondary diagnoses;

-- lack of socio-economic factors influencing health status;

-- the use of average length of stay as a proxy for resource consumption.

The flaws of the DRG system itself are then compounded by the imprecisions of DRG costing such as:

- -- non-comparability of hospital cost allocation;
- -- difficulty in isolating teaching costs;
- -- nonuniformity in hospital reporting;

The result is a DRG "cost standard" subject to attack and difficult to defend as an absolute dollar value. However, these imprecision problems can be better tolerated or at least diffused when DRG intensity weights are used instead. Thus, in New York we felt that even within the context of these limitations the DRG patient grouping is an effective tool. It certainly is an acceptable means by which to measure the relative case mix complexity of hospitals. By this I mean that even the most refined index will have shortcomings:

- We will always have reporting errors;
- We will never be able to adequately describe all patients to everyone's satisfaction;
- We can never hope to account for all hospital differences;
- We will never be able to precisely price out the cost of each case.

This is not meant to denigrate the DRG system; it simply reflects the fact that no system is without problems. In a world of close approximation, these case mix measurements certainly more than fit the bill. They represent a major step forward in enabling us to describe hospital activities in a discrete, distinct and manageable way; they have been sufficient for our purpose of relative complexity measures, not an objective number but as a measure relative to other institutions in the hospital system.

Of course, before completely abandoning the per diem system, the federal government must also ask itself what new problems this unit of payment by DRG may present. For example:

- -- Hospitals may increase their admission rates. Commenting on the payment for patient days, it has been said that "you get what you pay for". Similarly, payment for cases could well encourage a greater turnover of patients and admissions of cases that might otherwise be treated as outpatient. Therefore, admissions review and certification become important utilization review functions as has been recognized.

-- Hospitals may not be sufficiently reimbursed for aberrant cases. There are always patients representing exceptional treatment patterns whose status requires a greater amount of services than those normally accounted for under any average case payment. Such events are inevitable and some accommodation must be made either on an exception basis or built into the reimbursement system.

-- Under DRG payment there is likely to be a tendency for hospital staff to "over-report" the characteristics of their patient load. Since more complex cases result in higher payments, there is an incentive to provide a more detailed picture of patient mix. In fact, there is likely to be a general rise in the complexity rating of all hospitals to generate more income. It is interesting to note that because of age a substantial portion of Medicare patient cases are assumed to fall into complex diagnoses.

Although I have raised some of the incentive problems with DRG payments, none of these is really insurmountable. Rather, the single, most important dilemma facing the proposed federal system is not DRGs but the issue of a Medicare-only prospective system.

Our own experience in New York State, in fact, led us to conclude that an effective cost containment program requires that all payors participate. Otherwise, the primary effect is simply cost shifting among third-party payors. We started with a system for Medicaid and Blue Cross only and found that hospitals rapidly raised charges to private payors to a point where in some institutions charges are between 25-80 percent above cost. The net result of allowing hospitals to allocate costs from Medicare to other payors also reduces the impact of cost containment to Medicare. That is, the focus is on reallocating the same costs rather than on more effective and efficient management of hospital resources. At the extreme it may also offset the availabilty of adequate services to Medicare patients.

I raise this issue not to discourage the pursuit of a federal cost containment program. To the contrary, there is a dire need to balance the demand for essential health services with fiscal and economic realities. However, given the concern with the impact of cost shifting -- that it does not reduce the total health care cost to the public and undercuts the intended incentives for more cost efficient services -- there should be more stress concurrently on fostering all-payor systems by the states.

Certainly the intent of provisions of the Tax Equity and Fiscal Responsibility Act was to encourage the approval of more state waivers for comprehensive cost containment programs. Given the drawbacks of a Medicare-only system and the problems noted with a DRG payment system, I would strongly recommend that states be encouraged to continue the experimentation with all-payor systems using different methods of payment so that our learning process can continue. Certainly states which have demonstrated cost savings in the past should not have this experience held against them as has been the recent case with Massachusetts and New York. In both cases, HCFA has granted statewide waivers with the condition that their Medicare costs be kept 1.5 percent below the national rate of increase. Presumably, this was the "price" of choosing a state all-payor system versus the national Medicare-only or DRG based system of cost containment. In fact, the reverse should hold. The liabilities of a single-payor system instead should push the scales in favor of implementation by states of their own comprehensive programs. Requiring states to maintain Medicare costs at levels below as opposed to at the national average simply erodes provider support for these state alternatives. Such below average Medicare caps imposed by HCFA and the recently announced HCFA policy that all new state systems must use a DRG form of payment discourage all-payor systems and continued State experimentation since the Medicare-only program allows hospitals to avoid the risks of receiving less than they would have under the national system as well as to reap the benefits of cost shifting.

Another provision of the Administration's proposal that is of great concern relates to the "pass through" of capital costs while at the same time advocating the repeal of the health planning program.

The prospective payment system proposed will do nothing to moderate capital costs and, in fact, may encourage unnecessary capital expenditures to give hospitals competitive advantages under a DRG system.

New York is a strong advocate of a rational and aggressive health planning system at the local and state level as a complement to its prospective payment system.

In 1965, New York began the nation's first certificate of need program. Our health planning program has become an effective complement to our cost containment programs. Since 1975 and through these programs, we have removed over 12,000 excess beds from our hospital system, increased the efficient use of our remaining beds, and encouraged the development of alternative modes of care. However, we are now facing a new problem--one which other states will also face and which has the potential of restarting the cycle of escalating costs, forcing increased taxes, and increases in employee health insurance costs.

The scope of the problem quickly becomes evident when we look at the statistics on the total dollar amounts of capital construction in health care approved by New York State over the last few years. In 1979, the State approved $236 million in new projects and $369 million was sanctioned in 1980. In the last two years capital projects with initial cost estimates of $815 million received State approval. This year we are faced with projects totalling nearly $3 billion and by 1984 that figure will exceed $5 billion. This figure is well in excess of anything which we consider reasonable or acceptable in an era of limited and contracting resources.

By some estimates, the total capital costs including interest costs could be $10 to $15 billion. The cost to the federal Medicare program could be $6 billion.

New York is currently considering major changes in its certificate of need program to deal with this problem by adding the concept of relative need and affordability. Governor Cuomo has proposed a new capital budgeting process for hospitals and other health care facilities that will add discipline to this process. This will be developed during 1983.

As the Committee considers a cost containment system for Medicare, an improved system of health planning should also be considered. A planning process such as that envisioned in Section 1122 of the Social Security Act should be mandated so that capital is a part of the cost containment system that is put in place.

In closing, I only wish to encourage this Committee to build upon the lessons that we have learned in New York. Prospective reimbursement which employs DRGs for Medicare represents a major step towards an effective and equitable cost containment program. However, it is not enough. Hospitals are likely to continue to avoid hard management decisions by merely shifting costs to non-Medicare patients. States should be encouraged to be more aggressive in the designing of cost containment systems which best meet their needs and environments. This might build upon competitive approaches or the public utility model or some blend of these approaches. States given the proper incentives and encouragement can help solve the cost containment problem by further refining or creating programs that apply cost containment principles to all third-party payors. Such programs can be designed to recognize unique hospital problems and can be closely tied in a synergistic manner to health planning, utilization review, and other state-run programs. In short, the Congress as part of its consideration of a national cost containment program for Medicare should encourage the growth of cost containment systems by states which support and even strengthen national hospital cost containment goals.

Senator **Durenberger**. Mr. Pierce.

STATEMENT OF CHARLES F. PIERCE, DEPUTY COMMISSIONER OF HEALTH, STATE OF NEW JERSEY, TRENTON, N. J.

Mr. **Pierce**. Mr. Durenberger, thank you very much for inviting us. I have with me Joe Morris, the assistant commissioner, and Faith Goldsmith, our research specialist, in case your questions get highly specific.

I would also like to extend the best wishes of Governor Kean who intended to give this testimony but was unable to make it at the last minute.

We are here to speak for DRG's. First, I would like to share with you four specific results of great value that we have found by using DRG's. First, it is a clinically based reimbursement system. The allocation of resources is equitable, and it's based on a specific product—a diagnostic related group. Each hospital is reimbursed according to complexity and the volume of the cases it treats; not according to fixed payments per day.

Second, it provides a strong set of incentives for hospitals and physicians to use scarce resources. The DRG is the product focus and there are also incentives in our reimbursement system for efficiencies and disincentives for inefficiencies.

Most important, it provides a system by which you create a dialog between the medical staff and the hospital administration. And it's out of that dialog that we have seen a variety of very valid and very strong cost containment efforts take place within the hospital itself. This may be the most exciting aspect of the whole system in terms of long run benefits.

Third, in New Jersey there is equity across payers. All payers pay the same DRG in a particular hospital. This has eliminated the cost shifting which is so widespread throughout the rest of the country.

Fourth, and finally, in New Jersey, the cost for indigent care is a legitimate element of cost. And all hospitals, if they are well managed, are guaranteed solvency. And as a result, we find that our inner city hospitals are managing to remain fiscally solvent, and are now able to focus on the delivery of care.

I would like to respond to just a few points that were raised in the memo which you sent to all prospective speakers. One was on the DRG construction. As you know, the 467 DRG's were constructed by Yale University and the National Steering Committee. There was a great deal of clinical input into these new DRG's, the second set that we are now using. They appear to be meaningful both from the clinical and in a financial sense. Even insurance systems are telling us they are much preferable to the previous set.

In addition, we have seven categories to describe patients who are atypical in their length of stay or their resource consumption. These particular patients are grouped in outliers, and are billed according to charges.

The second point that you raised was about the data requirement. It is true that there is extensive computer capability required at the hospital level, at the intermediary level where they are processing the claims, and for those who set the rates. There ~~ust also be the ability to correct and check DRG assignments and claims and to generate and interpret reports. In addition, data submissions from the hospitals to the intermediaries must contain accurate data and it must be timely.

Third, on implementation, New Jersey found it exceptionally valuable to phase in the program over a 3-year period. And it's not until the system is in place that you begin to find out what the real problems are.

I would also like to add that education is an important element when you go into such a dramatically new program. Education about DRG's, how to manage under it at all levels, regulators, hospitals, physicians and patients—even the patients are essential—it is important that there be an independent monitoring system to make sure the quality of care is not damaged in any way. New technology can be introduced, and is through the certificate of need process as well as the system we call "clinical DRG appeal."

And, last, we would encourage you to make allowance for those States that wish to have the flexibility to implement the system for all payers. We have found it to be immensely valuable.

Thank you.

Senator **Durenberger**. Thank you very much.

[The prepared statement of Mr. Pierce follows:]

THE NEW JERSEY EXPERIENCE WITH DRG REIMBURSEMENT

by

Charles F. Pierce, Jr.
Deputy Commissioner

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CN 360
Trenton, New Jersey 08625

Prepared for Delivery Before
United States Senate Committee on Finance

Washington, DC

February 2, 1983

You and your colleagues on this committee are faced with an enormous task, one on which the future well-being of literally millions of Americans will depend. In this age of dwindling health resources, it is imperative that health care services be provided in the most efficient and effective manner possible. But cost containment efforts, if undertaken in haste and without adequate foresight, can substantially impair the ability of many of our sickest and most truly needy citizens to receive vitally necessary health services, and substantially damage, if not destroy, many of our most valued social institutions, such as urban hospitals, medical school teaching hospitals, and certainly public hospitals, as well as some rural hospitals that serve many of the poor.

Since there is a need to reduce the costs of health programs, you can do so either by reducing services or by reducing the payment for each unit of service.

We are beginning to learn in New Jersey, as has been previously demonstrated in Maryland, that well-conceived state programs to regulate hospital costs can effect considerable savings. Such programs are being implemented without serious restrictions on the availability of service or the financial viability of the providers of care, and indeed can even do much to improve the financial status of well-managed institutions which serve a disproportionately large number of poor citizens. The evidence on controlling the rate of increases in prices in the hospital sector in those states with mandatory cost containment programs is clear and encouraging. (See Attachment A).

New Jersey is one of those states with a mandatory cost containment program in place. A budget review per diem system (Standard Hospital and Rate Evaluation) went into effect in 1975. At the outset we believed that to truly contain hospital costs, it was necessary to reach the true resource consumer, the physician. Thus, the system had to be clincial in nature and take into account the differences in hospital case-mix. In 1976 work began on developing a prospective payment system based on Diagnosis Related Groups (DRGs). In 1980, twenty-six of New Jersey's acute care general hospitals implemented the DRG system. In 1981, thirty-five more implemented and by December 1, 1982, all 99 acute care general hospitals in New Jersey had implemented DRGs.

The heart of the New Jersey system is the ability of the Department of Health to actually calculate the cost of treating patients for a specific illness and treatment. The patient's bills, medical discharge abstracts and the hospital cost reports are used to calculate a direct patient care portion of the rate for each DRG. The direct patient care portion (which are those services such as nursing and ancillary services and medical supplies) is adjusted by factors for labor market area, urban-rural setting and teaching status.

A hospital specific mark-up factor is applied to the direct patient care portion to cover the hospital's indirect costs (which are those costs such as the debt service costs and administrative overhead). At the time of hospital billing of a DRG, a payer factor, which covers a portion of the hospital's indigent care costs, is applied.

In summary, a patient in New Jersey is billed:

Direct patient care rate
X mark-up factor
X payer factor
= total bill (DRG payment rate).

The DRG payment rate is the average amount of resources consumed in a hospital to treat a patient within a given DRG.

We feel that the DRG system has the following benefits:

(1) It is a clinically based system. The resources consumed are equitably distributed and based on specific produces - DRGs. Hospitals are reimbursed according to the severity and volume of their cases, not number of days. The 467 DRGs reflect severity of patients and the DRGs are meaningful both in a clinical sense and a financial sense.

(2) Hospitals are encouraged to use resources in an efficient manner. There is an incentive for hospitals to decrease expenditures through more effective clinical and financial management. This encourages dialogue between the administration, medical staff and hospital departments to

determine how to manage more effectively. The system is prospective so hospitals know their revenue and can plan ahead.

(3) In New Jersey, there is equity across all payers in that all payers pay a part of a hospital's uncompensated care. Therefore, cost shifting of the cost of this care does not occur.

(4) The hospital's reasonable financial elements, including indigent care costs, are covered. The hospital can now concentrate on effectively providing quality medical care to all patients irregardless of social or economic status.

DRG CONSTRUCTION

A. BASIC CONSTRUCTION

The DRGs used in New Jersey are the set of 467 DRGs developed by Yale University. Yale set up a National Steering Committee in 1979, and over the next two years the committee constructed a new set of DRGs, based directly on International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) codes.

A numeric code for every diagnosis and procedure is contained in three ICD-9-CM volumes. Every patient who is admitted to a hospital has a PRINCIPAL DIAGNOSIS, "the reason, after study, for admission". The principal diagnosis is used to group patients into broad categories called Major Diagnostic Categories (MDCs). The MDCs, for the 467 DRGs are arranged by organ system. For example, MDC 01 is Diseases and Disorders of the Nervous System, MDC 02 is Diseases and Disorders of the Eye. Clinical practice is based upon organ system so the physicians on the National Steering Committee felt that grouping diagnoses by organ system would best reflect medical practice.

Each MDC was subdivided into DRGs based on variables, such as age, sex, secondary diagnoses, procedures and discharge status, which made a significant difference in the length of stay (LOS) of patients. Length of stay is usually used as a surrogate for resource consumption.

In constructing the 467 DRGs, Yale used a nationwide sample of 1.4 million medical discharge abstract records plus 330 thousand New Jersey records which contained cost data as well as medical information. Cost data was used to confirm the relationship between length of stay and resource consumption. If resource consumption correlated with LOS for a DRG, there was no modification of the DRG. If resource consumption did not correlate, then modifications were made to the DRG.

The National Steering Committee was composed of representatives from Yale, New Jersey, HCFA, the Commission on Professional and Hospital Activities (CPHA), Public Health Service, and Johns Hopkins University. This committee membership was half physicians. In addition, a separate review structure was set up in New Jersey composed of physicians, medical record professionals, and other individuals with DRG expertise. The New Jersey group reviewed all decisions made by the Steering Committee and made recommendations based upon their experience with DRGs. The resulting MDCs and

DRGs are contained in a computer program called "GROUPER". There was a great deal of clinical input, as well as cost data correlation. Hence, the DRGs are meaningful in terms of actual clinical practice and "real life" experience.

B. OUTLIERS

Even with a sophisticated patient classification scheme such as DRGs, there are still those patients who are truly unique and cannot be compared to other cases. Those patients, because of their condition or treatment, have atypical resource consumption, and are considered "outliers".

New Jersey uses seven outlier categories - low length of stay, high length of stay, patients admitted and discharged the same date, patients who died, patients who left against medical advice, clinical outliers and low volume outliers.

Each DRG has a range of days that a typical patient would stay. The first day of the range is the "low trim" point, the last day of the range is the "high trim" point. Patients whose LOS is shorter than the low trim point are low length of stay outliers; patients whose LOS is longer than the high trim point are high length of stay outliers. Patients who were admitted and discharged on the same date, who died or who left against medical advise are considered atypical in terms of resource consumption in an acute care inpatient hospital setting.

There are also DRGs that were considered by the physicians to contain patients with diverse medical problems, so it was not equitable nor reasonable to set an "average" rate for the patients in those DRGs. Those DRGs are called "clinical outlier DRGs". In 1982 and 1983, there are 97 clinical outlier DRGs for purposes of billing.

In addition, there are hospital specific DRGs which have such a low frequency (fewer than 6), that an average rate for those DRGs could not be determined. Patients falling into such a low-volume DRG are considered outliers.

Patients in all outlier categories are billed itemized charges instead of the DRG payment rate.

The percentage of outlier categories in New Jersey's 1,141,968 1979 abstract records, regrouped into the 467 DRGs, is as follows:

Low LOS (including same day stays) = 8.7%
High LOS = 9.8
Deaths = 5.5
Left against medical advice = 1.8
Clinical outlier groups = 6.3
32.1%

About one-third of the inpatients in New Jersey hospitals in 1979 were atypical based upon the New Jersey outlier criteria.

C. SECONDARY DIAGNOSES, PROCEDURES, DRG CREEP

It was found in the old DRGs, that the order of secondary diagnoses or procedures could change DRG assignment and affect hospital reimbursement.

The term "DRG Creep" was coined to describe deliberate and systematic ordering of secondary diagnoses or procedures to obtain the highest reimbursement. In some instances, rearrangement of principal diagnosis was also attempted. DRG Creep was a problem with the old 383 DRGs because the computer could use only principal diagnosis, first listed secondary diagnosis, and principal procedure (very rarely were secondary procedures used). Therefore, hospitals could order the codes for maximum reimbursement.

New Jersey instituted strict definitions. First and most important, principal diagnosis was defined as the reason, after study, that the patient was admitted. In accordance with the Uniform Hospital Discharge Data Set definitions, additional diagnoses were to be coded only if they had bearing on the treatment or length of stay. There was a four part definition of principal procedure.

The view of New Jersey was that if a hospital did indeed treat a patient for a severe secondary or perform multiple severe procedures, then the reimbursement should be reflective of this resource consumption. However, the necessity for treatment must be documented in the medical record, and those procedures performed must also be documented.

So, not only did the State of New Jersey institute strict definitions of what diagnoses and procedures could be coded for DRG assignment, it also mandated that documentation for everything be present in the medical record.

DRG Creep is not a problem with the 467 DRGs. The computer program selects the secondary diagnosis codes or procedure codes needed for DRG assignment. The ordering of the codes does not matter because GROUPER searches all codes listed in the record. This computer program is "smarter" than the old program. Significant secondary diagnoses and procedures which affect resource consumption will be taken into account when the payment rates are calculated.

DATA REQUIREMENTS

The data requirements for the DRG patient classification system are massive. The proposed Medicare Prospective Payment System (PPS) may not have the same sheer volume of data (abstracts, bills, cost reports and Uniform Bill-Patient Summary) but the principles will still apply.

Hospitals must have computer capabilities. The 467 DRGs cannot routinely be assigned by hand. There must be the capability for all pieces of a patient's record to flow to a central point for DRG assignment. (See Attachment B). Collection of the pieces and DRG assignment must be done as rapidly and efficiently as possible. There must be the capability to verify and correct records. There must be the clincial or financial management information. Above all, the hospital and its billing and medical abstract vendors must understand how to work with the DRG system.

Hospitals are not the only agencies which need to have computer capabilities. The volume of data received necessitates computer capability at the intermediary and payer level. They must have the ability to collect, verify and correct data submissions. They must be able to check DRG assignment and dollars charged. They must have edit and submission checks to obtain accurate data on a timely basis. Data requirements and timeliness for data submission should be worked out ahead of time and then enforced.

IMPLEMENTATION

During 1978 and 1979, while in a developmental mode, New Jersey established experimental rates for approximately 20 hospitals. The rates were based upon available data sets and various methods of calculation were utilized. This experiment allowed refinement of both the data sets and the methodology as a result of the hospital's experience with the experimental rates.

Even though New Jersey had a two year simulation, implementation brought additional problems which were not fully anticipated. Examples of these problems were data management (at all levels) and concern about quality medical care.

A. DATA MANAGEMENT

The logistics of data management and reporting presented an enormous challenge. There have been refinements made each year and continued simplification. Despite these refinements, one of New Jersey's main problems remains the sheer volume of data and the errors involved in manipulation of a massive data base (1.2 million hospital inpatients per year). Data quality, timeliness of submissions, correction turn-around time, and programming have all presented problems. These problems were uncovered in 1980 when New Jersey implemented the DRG system for 26 hospitals, two intermediaries, and 380 thousand patients. It is conceivable that Medicare may experience some difficulties implementing a system for 6,000 hospitals, 100 intermediaries and 10 million patients. The phasing-in process utilized by New Jersey, allowed the discovery and correction of problems while dealing with only 26 hospitals rather than all 100 acute care hospitals.

B. QUALITY OF CARE

Since the DRG system provides incentives for hospitals to reduce LOS, there was concern expressed that quality of care would suffer (e.g. patients discharged too early). Likewise, since there is an incentive for hospitals to decrease unnecessary resource consumption, the question of decreasing quality by utilizing fewer tests or other resources was raised by some critics of the DRG system. The Professional Standard Review Organizations (PSROs) have become the focal point for addressing quality of care issues. New Jersey has found no evidence that quality of care has diminished under the DRG system.

While great care can be taken to anticipate and resolve problems prior to implementation, additional problems will be discovered when the system is actually in place and functioning. It was for this reason that New Jersey phased-in hospitals over several years. A phase-in of the system affords the opportunity to correct problems with fewer repercussions.

OTHER ISSUES

A. EDUCATION

There are several other issues that should be raised. The first is the tremendous importance of education for hospitals, physicians, patients, intermediaries, PSROs, and planning agencies. Hospitals must understand how to use DRGs to manage clinically and financially in the most efficient manner. The importance and dire necessity of thorough education of a hospital's medical staff cannot be over-emphasized. Physicians must understand their role in hospital resource consumption. Patients must understand the classification and billing. Intermediaries must understand DRG assignment and claim check. PSROs must understand their role in assuring quality data and quality care under DRGs. Planning agencies must be able to use DRGs as tools to make their planning decisions.

If the entire hospital is not involved in the DRG system, then the hospital cannot effectively function under DRGs. Attachment C lists areas of management consideration for a hospital going onto DRGs.

New Jersey has had many calls from outside the State from agencies and individuals concerned about DRGs and Medicare. The level of knowledge ranged from some familiarity to total ignorance of even simple data requirements.

B. MONITORING

The second issue is the importance of monitoring quality of care. Quality of care is very difficult to measure. Can quality be measured by a criterion such as outcome - alive/dead? In New Jersey, we believe that peer review is an important component in monitoring quality of care, and the PSROs serve this function. The value of an independent organization to monitor the utilization of hospital care cannot be refuted.

C. NEW TECHNOLOGY

Third, there should be a mechanism for addressing new technology. In New Jersey, the Rate Setting Commission hears testimony from a hospital (or hospitals), the Department of Health, and the Commissioner's Physician Advisory Committee. If evidence is available that a new technological advance is worthwhile, then the hospital is awarded additional reimbursement.

The hospital can also obtain additional reimbursement for new technology through the appeals process for those approved certificate of need projects.

D. STATE FLEXIBILITY

It is important to note that while the problems of rising hospital costs may be similar nationally, a prospective payment system may not have identical results in Idaho as in Pennsylvania. In those instances where a state can implement their own system, designed to meet the federal objective, then flexibility for state initiatives should be allowed.

SUMMARY

In conclusion, we in New Jersey have been working with DRGs since 1976. We feel very strongly that DRGs have a great benefit in terms of allowing hospitals to use available resources wisely and to help contain health care costs for payers and consumers.

Now that all New Jersey acute care general hospitals are finally billing by DRGs, we should be in a position to see exactly how much of an impact DRGs can have on a state's health care expenditures and clinical management.

ATTACHMENT A

Material from
Report to Congress
Hospital Prospective Payment
for Medicare

December 1982

Richard S. Schweiker
Secretary
Department of Health and Human Services

U.S. COMMUNITY HOSPITALS
1975-1980
PERCENT INCREASE
EXPENSE PER ADJUSTED ADMISSION

RANK	STATE	CUMULATIVE INCREASE	ANNUAL INCREASE	
1	ALASKA	149.67	20.08	
2	DISTRICT OF COLUMBIA	123.12	17.41	
3	NEVADA	111.88	16.20	
4	NEW MEXICO	111.71	16.18	
5	MONTANA	109.36	15.93	
6	WYOMING	108.14	15.79	
7	HAWAII	107.54	15.72	
8	UTAH	104.99	15.44	
9	KANSAS	100.13	14.88	
10	NORTH DAKOTA	97.30	14.56	
11	COLORADO	96.97	14.52	
12	SOUTH DAKOTA	96.18	14.43	
13	MAINE	96.08	14.42	
14	CALIFORNIA	95.23	14.32	
15	OKLAHOMA	94.57	14.24	
16	MISSOURI	93.22	14.08	
17	IDAHO	92.37	13.98	
18	ARKANSAS	90.78	13.79	
19	ILLINOIS	90.13	13.71	
20	IOWA	90.00	13.70	
21	WEST VIRGINIA	89.81	13.67	
22	OREGON	89.34	13.62	
23	TEXAS	88.20	13.48	
24	VIRGINIA	88.04	13.46	
25	WISCONSIN	87.93	13.45	MANDATORY*
26	ALABAMA	87.73	13.42	
27	OHIO	86.57	13.28	
28	MINNESOTA	85.14	13.11	
29	SOUTH CAROLINA	84.52	13.03	
30	PENNSYLVANIA	84.48	13.03	
31	LOUISIANA	83.95	12.96	
32	INDIANA	83.92	12.96	
33	TENNESSEE	83.80	12.95	
34	MISSISSIPPI	83.42	12.90	
35	NORTH CAROLINA	82.60	12.80	
36	KENTUCKY	82.02	12.73	
37	ARIZONA	80.69	12.56	
38	NEW HAMPSHIRE	78.69	12.31	
39	WASHINGTON	78.02	12.23	MANDATORY *
40	FLORIDA	77.98	12.22	
41	GEORGIA	77.49	12.16	
42	MICHIGAN	76.91	12.09	
43	NEBRASKA	74.47	11.77	
44	MASSACHUSETTS	72.41	11.51	MANDATORY*
45	NEW JERSEY	68.22	10.96	MANDATORY*
46	DELAWARE	67.56	10.87	
47	RHODE ISLAND	67.42	10.86	MANDATORY*
48	MARYLAND	67.23	10.83	MANDATORY*
49	CONNECTICUT	65.51	10.60	MANDATORY*
50	VERMONT	63.14	10.28	
51	NEW YORK	51.62	8.68	MANDATORY*

U.S. Average	79.60	12.42
Mandatory	61.83	10.1
Non-Mandatory	86.59	13.29

*Those programs which require hospitals both to participate and comply.

TABLE 2

PROSPECTIVE PAYMENT EXPERIENCE:
ANNUAL PERCENT INCREASE IN INPATIENT HOSPITAL COSTS
DEMONSTRATION STATES VS UNITED STATES

Community Hospitals: Annual Percent Increase
Inpatient Cost Per Capita

States with Demonstrated Programs	1977	1978	1979	1980	1981
Connecticut	10.6	9.4	9.0	12.6	14.1
Maryland	11.3	11.8	15.1	14.5	16.0
Massachusetts	11.9	7.3	8.2	13.9	14.4
New Jersey	11.7	8.8	10.6	15.8	11.5
New York	11.5	7.5	10.0	11.5	15.2
Rhode Island	10.0	6.7	12.9	14.0	15.0
Washington	11.9	7.0	9.1	11.3	21.8
Wisconsin	10.2	11.5	10.8	14.7	16.9
United States	12.8	11.1	12.0	14.9	17.7

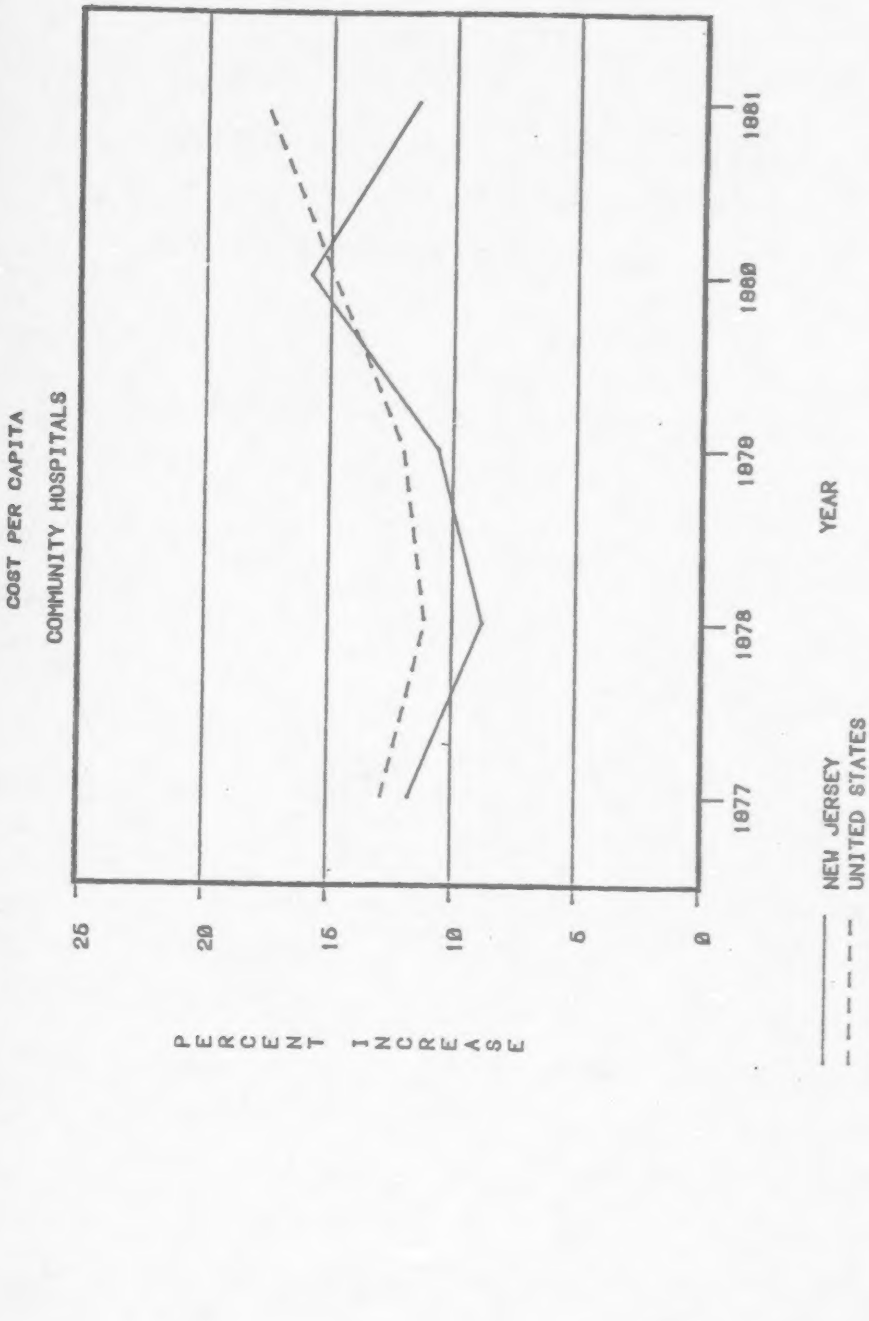
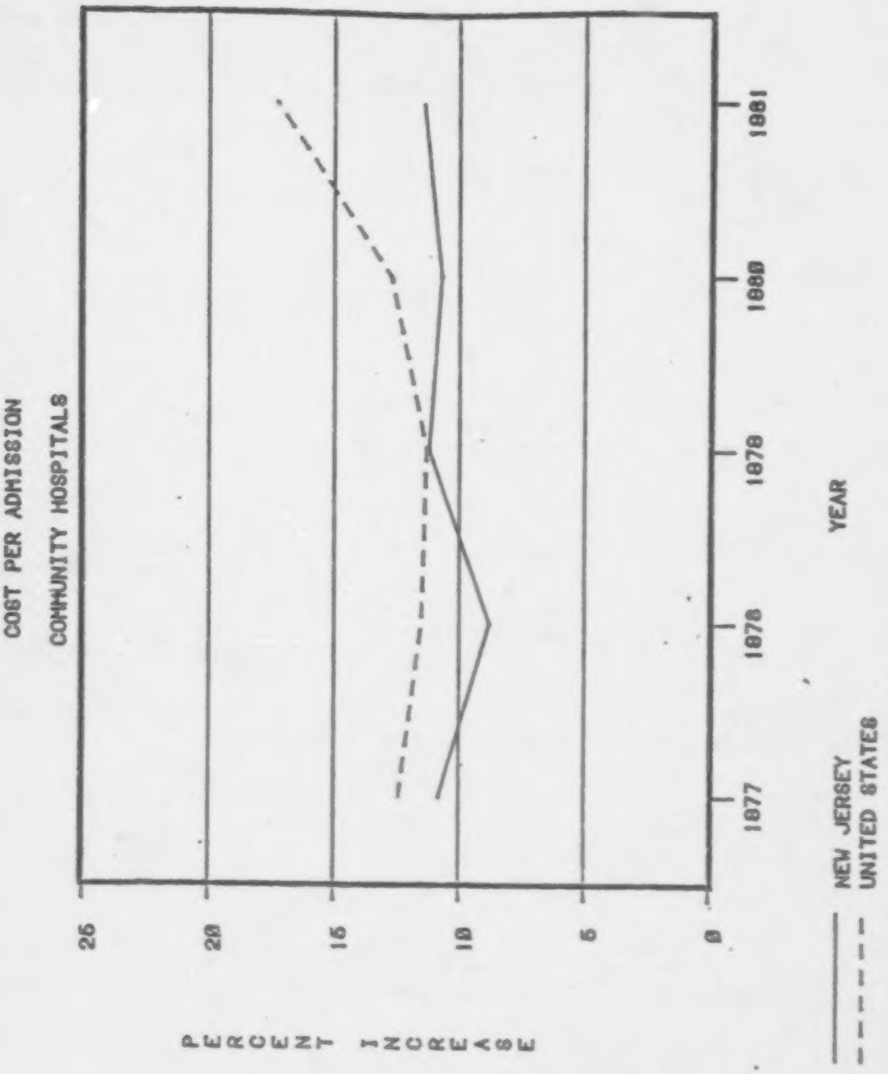

COST PER CAPITA
COMMUNITY HOSPITALS
PERCENT INCREASE
25
20
15
10
5
0
1977
1978
1979
1980
1981
YEAR
NEW JERSEY
UNITED STATES

TABLE 3

PROSPECTIVE PAYMENT EXPERIENCE:
ANNUAL PERCENT INCREASE IN INPATIENT HOSPITAL COSTS
DEMONSTRATION STATES VS UNITED STATES

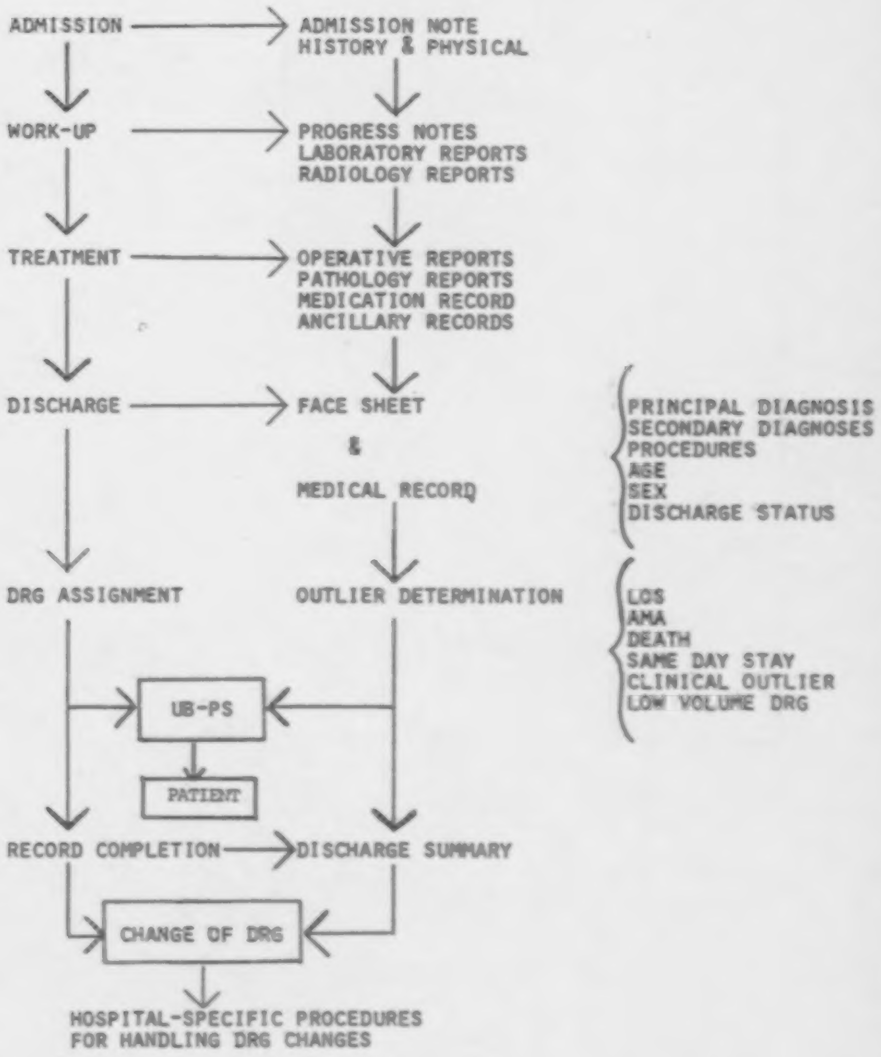
Community Hospitals: Annual Percent Increase
Cost Per Adjusted Admission

States with Demonstrated Programs	1977	1978	1979	1980	1981
Connecticut	11.1	9.5	8.1	11.4	15.9
Maryland	8.9	9.2	12.1	9.8	15.6
Massachusetts	13.8	8.1	7.6	14.1	14.1
New Jersey	10.8	8.8	11.2	10.7	11.4
New York	7.0	8.5	8.5	10.8	14.1
Rhode Island	9.5	6.1	10.9	12.4	16.3
Washington	12.9	10.5	11.2	10.9	18.9
Wisconsin	12.5	12.7	10.7	12.6	17.6
United States	12.4	11.5	11.3	12.7	17.3


COST PER ADMISSION
COMMUNITY HOSPITALS
PERCENT INCREASE
25
20
15
10
5
0
1977
1978
1979
1980
1981
YEAR
NEW JERSEY
UNITED STATES

ATTACHMENT B

INFORMATION FLOW


ADMISSION
ADMISSION NOTE
HISTORY & PHYSICAL
WORK-UP
PROGRESS NOTES
LABORATORY REPORTS
RADIOLOGY REPORTS
TREATMENT
OPERATIVE REPORTS
PATHOLOGY REPORTS
MEDICATION RECORD
ANCILLARY RECORDS
DISCHARGE
FACE SHEET
&
MEDICAL RECORD
PRINCIPAL DIAGNOSIS
SECONDARY DIAGNOSES
PROCEDURES
AGE
SEX
DISCHARGE STATUS
DRG ASSIGNMENT
OUTLIER DETERMINATION
LOS
AMA
DEATH
SAME DAY STAY
CLINICAL OUTLIER
LOW VOLUME DRG
UB-PS
PATIENT
RECORD COMPLETION
DISCHARGE SUMMARY
CHANGE OF DRG
HOSPITAL-SPECIFIC PROCEDURES
FOR HANDLING DRG CHANGES

ATTACHMENT C

Management Considerations

1. Staffing	Personnel requirements Training
2. Systems analysis	Review Discharge processing Chart completion Timing of DRG assignment Computerization - vendors
3. Interaction with other departments	Admissions Billing/Finance Utilization review DRG Coordinator Administrator Medical Records Nursing Social Services
4. Physician involvement	Accuracy of information Timeliness of record completion Education - DRGs and MDs
5. Monitoring - internal and external	Accuracy of DRG assignment Data quality Incomplete charts Edits on UB-PS, abstracts Outside monitoring
6. Data Analysis	Managment reports - DRG Volume frequency Physician & service Outliers Cost analysis Others - LOS, variance

THE NEW JERSEY EXPERIENCE WITH DRG REIMBURSEMENT

SUMMARY

Mr. Chairman, members of the committee, my name is Charles Pierce. I am Deputy Commissioner of the New Jersey State Department of Health. With me are Joseph Morris, Acting Assistant Commissioner and Faith Goldschmidt, Health Economics Research Specialist I.

New Jersey acute care general hospitals instituted the Diagnosis Related Group (DRG) System as a means of hospital reimbursement by all patients in 1980.

Our hospitals were phased in over a three year period and all had implemented DRG as of December 1, 1982.

We feel that the DRG System has the following benefits:

1. It is a clinically based system. The allocation of resources is equitable and based on a specific product - a DRG. Each hospital is reimbursed according to the complexity and volume of the cases it treats, not according to a fixed rate per day irregardless of the clinical experience of that hospital.

2. Hospitals are encouraged to use resources in an efficient manner by the use of incentives for efficiency and disincentives for inefficiencies.

The DRG system provides valuable information for a hospital to communicate with its medical staff. The physician is the true resource consumer, as he admits the patient, orders all services and discharges the patient. Using the management reports, physicians can more effectively manage their cases.

3. In New Jersey, there is equity across payers in that all payers pay a portion of each hospital's cost for providing care for indigent patients.

4. Hospitals no longer need to cost shift to cover indigent care so they can concentrate on effectively and efficiently providing quality medical care for all patients irregardless of social or economic status.

Information on the following topics was specifically requested by the Subcommittee:

1. DRG Construction

The 467 DRGs used were constructed by Yale University and the National Steering Committee. There was a great deal of clinical input into the new DRGs, and they are meaningful both in the clinical and financial sense. New Jersey uses 7 categories to describe patients atypical in length of stay or resource consumption. These patients are "outliers" and are billed charges.

2. Data Requirements

There must be computer capability at the hospital and intermediary level. There must also be the ability to check and correct DRG assignment and claims, and generate and interpret reports. Data submissions must contain accurate data and be timely.

3. Implementation

Based upon New Jersey's three year implementation phasing in of hospitals is very important. Until a system is actually in place and being used, all of the problems cannot be found.

4. Miscellaneous Issues

a. There is great need for education about the system at all levels - regulator, hospitals, physicians, and patient.

b. There is also need for an independent monitoring system so that quality of care does not deteriorate under incentives to reduce expenditures.

c. New technology is addressed in New Jersey by the Rate Setting Commission, either by a specific appeal or by the Certificate of Need mechanism.

d. Allowance should be made for states to have the flexibility to implement their own systems, provided such systems will meet the Federal objectives of cost containment.

Senator **Durenberger**. Mr. Cohen, before you make your remarks, there are two things. One, I am going to compliment you in advance for some of the news you are going to share with us today about Maryland. And also on behalf of the members of the committee and the staff of this committee thank you for all your help last year in trying to help us deal with the TEFRA provisions. Obviously, to the the degree that they aren't realistic, it's our fault. To the degree that they were, we owe you a debt of gratitude. So thank you for being here today also.

STATEMENT OF MR. HAROLD COHEN, EXECUTIVE DIRECTOR, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION, BALTIMORE, MD.

Mr. **Cohen**. Thank you very much, Mr. Chairman.

As you indicated, today happens to be the day that Maryland provides its annual disclosure. And hospital cost increases per admission went up 12.1 percent in Maryland, compared to a national average of 16.7. Our estimate is that if it was compared with the unregulated States, it would be a difference of about 5½ percent, which in Maryland alone would be $80 million, and Maryland is 2 percent of the business. So the national implication is quite significant.

The testimony that I submitted and which I am going to summarize rather briefly endorses the replacement of retrospective cost reimbursement by a prospective payment system. Incentive based prospective payment systems can change hospital behavior by putting hospitals at risk for both the cost of individual departments and the way medicine is practiced in their hospitals.

The major cost questions relate to length of stay and the intensity of treatment. The cost of treating patients with different diseases varies considerably. Thus, the Department's choice of a case mix adjusted admission as the payment unit we believe is superior to a patient day or certainly superior to departmental charges. I actually suggested that you may wish to use the medicare spell of illness as even a better measure because it protects against readmissions and interhospital transfers. And medicare's data base should be able to accommodate that since they have to be prepared to pay for care on the basis of their own spell of illness information.

While we believe Congress should adopt major portions of this proposal, it should also recognize that the major social problem is the proportion of our resources going to hospital care. Congress should support activities designed to prevent cost shift from the citizen's tax pocket to their other pockets. And, of course, that includes support of those States which wish to run all payer systems which themselves control such kinds of shifting.

I would suggest that you institute a volume adjustment formula or some other protection against interhospital transfers and readmissions. That a limit should be set for the increase allowed under the capital pass through, and make equipment payments on a prospective basis. I think the system can be modified to handle that. And I submitted a specific proposal to do that.

I suggest that a limit to payment increases to outpatient care be established to protect against cost allocations designed to remove costs from inpatient control system. I suggest that hospital accounting is an art. Hospital accountants are very artful in being able to transfer costs to where they get reimbursed by cost. And if you take cost for outpatients and prospective charges for inpatients, you will find that the cost of outpatients will rise rather dramatically.

Associated with that, I would also add to my prefiled testimony a recommendation that medicare pay only hospitals for the technical care associated with radiology, pathology, and those other kinds of services which hospitals can leave out. Hospitals allow those to be franchised out, and also negotiate the way of paying for those services. This will make sure that medicare only pays once for those services.

I'm rather concerned about the protection afforded the trust fund by saying that medicare will monitor this leasing, especially when different providers can use intermediaries, and the intermediaries may not even know what is going on as far as the separate payment for services is concerned.

I would hope that you would use job mix adjusted hourly payment information to develop the wage adjustment. We spend a lot of effort allocating patients into 356 categories but we have left employees in one category. I think that we have to do a better job in order to make the intermarket wage comparison.

For example, if you look at the HCFA information, the wage adjustment for Syracuse, N.Y., is 43 percent higher than the wage adjustment for Rochester, N.Y. They are less than 2 hours apart. I just can't believe that an economic market would allow that difference to exist. It has to be a data problem in my opinion.

I would also urge the committee to recognize an additional reason for realizing the teaching hospital's need more money than an unadjusted DRG average. I'm concerned that you might conclude that the reasons given in the HCFA proposal for giving teaching hospitals additional money are not substantive; and that, therefore, they shouldn't get the additional money. I proposed another reason, which I think is technically correct. It suggests that they are being underpaid on an averaging system because medicare's own pricing system requires a great deal of averaging in the charges within DRG. The use of identical daily routine charges, the use of identical hourly rates in the OR and of similar charging methods in the individual departments tends to underprice heroic medicine and overprice routine medicine in our teaching hospitals.

And, of course, I would recommend that states with data bases superior to medicare's be able to use that information both to help medicare get answers to some of the questions that are left open, and, of course, to use them to set medicare rates along with other rates.

We, in Maryland, as well as New York and New Jersey, don't have to rely on a 20 percent Medpar sample. We can rely on 100 percent of everything, of every medicare discharge for several years. If you want to take into account demographic information, we can do that. And it does make a difference. We should be allowed to use that information to come up with an equitable payment system and to help give reports to HCFA.

I might also indicate that we have worked with HCFA for quite a while now. And they have several very competent individuals who can respond to the technical questions that I raised in my testimony.

Finally, I would simply urge that you do adopt changes in your tax law so that expenditures on health care compete more fairly with other forms of expenditures, compensation and investment, and give those people who should be fighting the effect of shifting some reason to fight back when costs are shifted to them.

Thank you very much.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Mr. Hal Cohen follows:]

REMARKS OF
HAROLD A. COHEN
MARYLAND HEALTH SERVICES COST REVIEW COMMISSION
BEFORE THE
SENATE FINANCE COMMITTEE
FEBRUARY 2, 1983

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

GOOD AFTERNOON. MY NAME IS HAROLD A. COHEN AND I AM THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION. THE COMMISSION IS A STATE AGENCY CREATED IN 1971 WHICH HAS BEEN SETTING PROSPECTIVE HOSPITAL RATES FOR MARYLAND HOSPITALS SINCE 1975. SINCE JULY 1, 1977, THESE RATES HAVE APPLIED TO MEDICARE AND MEDICAID BY AUTHORITY OF A WAIVER AGREEMENT ENTERED INTO WITH THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) UNDER SECTION 1814 (b) OF THE SOCIAL SECURITY ACT AMENDMENTS OF 1972. ACCORDING TO DATA MUTUALLY AGREED UPON BY US AND HCFA AS PART OF OUR EVALUATION (OR "CAP") TEST, THE MARYLAND PROSPECTIVE SYSTEM HAS PRODUCED SUBSTANTIAL SAVINGS -- $74,000,000 FOR MEDICARE AND $49,000,000 FOR MEDICAID. MOREOVER, THESE SAVINGS HAVE BEEN ACHIEVED WITHOUT HARMING HOSPITAL FINANCIAL VIABILITY. SINCE JULY 1977, WHEN MEDICARE AND MEDICAID JOINED OUR SYSTEM, HOSPITAL PROFITS INCREASED, AND HOSPITALS TREATING LARGE NUMBERS OF INDIGENT PATIENTS HAVE BEEN PLACED ON A FAR MORE SECURE ECONOMIC FOUNDATION.

LET ME MAKE A FEW BRIEF DESCRIPTIVE COMMENTS ABOUT OUR SYSTEM BEFORE I COMMENT ON THE MEDICARE PROPOSAL. FIRST, WE OPERATE AN ALL PAYOR SYSTEM WHOSE AIM IS TO CONTAIN THE TOTAL RESOURCES CONSUMED BY THE HOSPITAL SECTOR. SECOND, WE RELY HEAVILY ON FINANCIAL INCENTIVES TO MOTIVATE DESIRED CHANGES

IN HOSPITAL BEHAVIOR. WE BELIEVE THERE IS NOTHING INAPPROPRIATE IN ANY HOSPITAL -- PROPRIETARY OR NON-PROFIT -- MAKING PROFITS IF THESE PROFITS ARE ACHIEVED THROUGH EFFICIENCY. FINALLY, WE BELIEVE THAT THERE IS SOMETHING WRONG IN FINANCING HUGE INCREASES IN HOSPITAL COSTS EVERY YEAR WHEN OTHER EQUALLY IMPORTANT SOCIAL NEEDS ARE BEARING THE BRUNT OF RESOURCE CUTBACKS.

YOU ARE PROBABLY INTERESTED IN THE EXTENT OF SAVINGS ACHIEVABLE IN A PROSPECTIVE HOSPITAL PAYMENT SYSTEM. BY A COINCIDENCE OF SCHEDULING, I AM ABLE TO REPORT TO YOU THE FISCAL RESULTS OF OUR SYSTEM FOR THE FISCAL YEAR ENDING JUNE 30, 1982 WHILE THE COMMISSION'S CHAIRMAN, DAVID SCHEFFENACKER, IS GIVING THE ANNUAL DISCLOSURE REPORT IN BALTIMORE. THIS REPORT IS TRADITIONALLY PRESENTED AT THE HSCRC'S FEBRUARY MEETING. WHILE THE NATIONAL AVERAGE INCREASE IN COST PER DAY WAS 17.0%, THE RATE OF INCREASE IN MARYLAND WAS 14.2%. THIS AMOUNTS TO A SAVINGS, FROM THAT PERSPECTIVE, OF $39.5 MILLION. FROM THE MORE IMPORTANT PERSPECTIVE OF COST PER ADMISSION, THE NATIONAL INCREASE (AS SUPPLIED BY THE AMERICAN HOSPITAL ASSOCIATION) WAS 16.7%. MARYLAND'S RATE OF INCREASE IN COST PER ADMISSION WAS 12.1%. THIS DIFFERENCE AMOUNTS TO A $68.3 MILLION SAVINGS FOR MARYLAND VERSUS THE NATIONAL EXPERIENCE. IF OUR SYSTEM'S RESULTS WERE COMPARED TO THOSE OF NON-REGULATED STATES, OUR ESTIMATED SAVINGS PER ADMISSION WOULD BE 5 1/2% OR APPROXIMATELY $80 MILLION. SINCE MARYLAND ACCOUNTS FOR ONLY 2% OF THE NATION'S HOSPITAL EXPENDITURES, THE SAVINGS POTENTIAL INDICATED BY EXTRAPOLATING OUR APPROACH TO OTHER STATES IS VERY SUBSTANTIAL. THIS POTENTIAL IS ENHANCED BY THE FACT THAT OUR RELATIVE SAVINGS WERE ACHIEVED

BY FURTHER CONSTRAINING A COST BASE WHICH HAS BEEN REGULATED FOR SIX YEARS. THE CUMMULATIVE SYSTEM-WIDE SAVINGS GENERATED IN MARYLAND OVER THE PAST SEVEN YEARS IS APPROXIMATELY $1 BILLION ON A TOTAL STATE/FEDERAL EXPENDITURE OF APPROXIMATELY $9 MILLION. THESE SEVEN YEARS HAVE SEEN MARYLAND'S HOSPITALS REDUCE THEIR COSTS PER DAY FROM 20% ABOVE THE NATIONAL AVERAGE TO SLIGHTLY BELOW THE NATIONAL AVERAGE WHILE IMPROVING THEIR MANAGEMENT AND THEIR FISCAL SOLVENCY. THUS, MY FOLLOWING REMARKS CONCERNING THE PROPOSED MEDICARE PROSPECTIVE SYSTEM ARE BASED UPON A LONG AND REASONABLY SUCCESSFUL EXPERIENCE WITH A PROSPECTIVE, INCENTIVE-BASED HOSPITAL PAYMENT SYSTEM.

THE FIRST IMPORTANT QUESTION FOR YOU TO CONSIDER IS WHETHER CONGRESS, HAVING DIRECTED DHHS TO PROPOSE A PROSPECTIVE PAYMENT SYSTEM (P.P.S.), SHOULD IN FACT CHANGE THE MEDICARE PAYMENT SYSTEM FROM RETROSPECTIVE COST REIMBURSEMENT (RCR). I STRONGLY URGE THAT YOU MAKE THIS CHANGE. UNDER RCR, A HOSPITAL IS ESSENTIALLY AT RISK FOR NOTHING. VERY FEW HOSPITALS HAVE BEEN DENIED ANYTHING UNDER SECTION 223 AND THE UPWARD DRIFT OF HOSPITAL COSTS HAS NOT BEEN CONTROLLED. UNDER P.P.S., A HOSPITAL IS AT RISK FOR PERFORMANCE WHICH DOES NOT MEET THE EFFICIENCY STANDARDS USED IN THE DEVELOPMENT OF THE PROSPECTIVE RATES. AS TABLE 1 ON PAGE 6 OF SECRETARY SCHWEICKER'S REPORT SHOWS, HOSPITALS CAN CONTROL THEIR COSTS TO A MUCH GREATER EXTENT THAN RCR REQUIRES AND P.P.S. GIVES THEM FAR MORE PROTECTION FROM THE "UNCONTROLLABLE" ASPECTS OF THE ECONOMY THAN NORMAL BUSINESSES WITH UNINSURED CLIENTS ENJOY IN THESE DIFFICULT ECONOMIC TIMES. FOR SEVERAL YEARS NOW, HOSPITAL UNIT COSTS HAVE BEEN GROWING MORE RAPIDLY THAN INFLATION AND HOSPITAL TOTAL EXPENDITURES HAVE BEEN GROWING MORE RAPIDLY

THAN GNP. THESE GROWTH RATES LEAVE FEWER DOLLARS AVAILABLE FOR OTHER SOCIAL CONCERNS. WHILE HOSPITALS COMPLAIN THAT DHHS MAY NOT GIVE THEM ENOUGH TO COPE WITH INFLATION OR ENOUGH MONEY TO ADOPT ALL SORTS OF COST INCREASING TECHNOLOGY, OTHER SOCIAL SERVICES -- MANY OF WHICH CONTRIBUTE MORE TO THE HEALTH OF THE PEOPLE -- ARE LUCKY IF THEIR BUDGETS INCREASE BY HALF OF INFLATION. WHILE HOSPITALS CLAIM THAT P.P.S. MAY MAKE IT MORE DIFFICULT FOR THEM TO BORROW TO UPGRADE PHYSICAL FACILITIES AND POINT TO A MAJOR CAPITAL NEED FOR HOSPITALS, THE HOSPITAL PLANT IN THIS COUNTRY IS MUCH MORE MODERN THAN OUR MANUFACTURING, EDUCATION AND TRANSPORTATION FACILITIES. NEVERTHELESS, WE GIVE HOSPITALS HUGE TAX ADVANTAGES IN RAISING FUNDS. FURTHER, BY USING THE PRIOR YEAR'S INFLATION AS THE FORECASTER OF THE NEXT YEAR'S INFLATION, HOSPITALS ARE PAID FOR INFLATION OVER TIME, SOMETIMES BEING A LITTLE AHEAD AND SOMETIMES A LITTLE BEHIND IN CASH FLOW.

THE NEXT MAJOR QUESTION IS WHETHER A PROSPECTIVE SYSTEM FOR MEDICARE WILL RESULT IN REDUCED HOSPITAL EXPENDITURES OR IN A SHIFTING OF THE BURDEN OF PAYING FOR INCREASES FROM MEDICARE TO OTHER PAYORS. SOME OPPONENTS OF P.P.S. FOR MEDICARE ARGUE THAT HOSPITALS WILL NOT CHANGE THEIR BEHAVIOR BUT WILL SIMPLY SHIFT THE COST RESULTS OF THAT BEHAVIOR ONTO OTHER PAYORS. I AGREE WITH THOSE WHO ARGUE THAT THE IMPORTANT PROBLEM IN HOSPITAL FINANCING IS THE TOTAL LEVEL OF RESOURCES CONSUMED BY THE HOSPITAL SECTOR. I DO NOT BELIEVE THE VALUE RECEIVED FOR THE MARGINAL BILLIONS SPENT FOR HOSPITAL CARE IS WORTH THE EXPENDITURE. I DO NOT THINK THEY MAKE SENSE WHETHER WE PAY FOR THEM OUT OF OUR TAX POCKET, OUR HEALTH INSURANCE POCKET, OUR PAYCHECK POCKET, OR ANY OTHER POCKET. IT IS IMPORTANT FOR YOU TO

CONTROL WHAT WE PAY OUT OF OUR TAX POCKET BUT YOU SHOULD ALSO ALTER THE TAX LAWS REGARDING HEALTH INSURANCE AND ALLOW OTHER APPROACHES WHICH PROTECT ALL OUR POCKETS. IN PARTICULAR, YOU SHOULD AT LEAST PERMIT, AND PROBABLY ENCOURAGE, STATES TO MEET NATIONALLY ESTABLISHED EXPENDITURE TARGETS WITHIN THE CONTEXT OF AN EQUITABLE PAYMENT STRUCTURE. THIS POSITION AGREES WITH THOSE TAKEN BY BOTH THE NATIONAL GOVERNORS' ASSOCIATION AND THE NATIONAL COUNCIL OF STATE LEGISLATORS.

THUS, I STRONGLY ENCOURAGE YOU TO ADOPT A PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE,TO ALTER THE TAX LAWS, AND TO OTHERWISE ENCOURAGE THE EFFICIENT PURCHASE OF HOSPITAL CARE WHILE ALLOWING STATES TO INDIVIDUALLY RESPOND TO YOUR PERFORMANCE CRITERIA. OVER TIME, THOSE CRITERIA SHOULD ADDRESS THE MAJOR PROBLEM REGARDING TOTAL RESOURCE USE AND NOT SIMPLY TO THE FEDERAL BUDGET PROBLEMS.

HAVING STRONGLY ENDORSED THE IDEA OF A P.P.S. FOR MEDICARE, I WILL TURN TO THE PROPOSAL BEFORE YOU. THE FIRST MAJOR QUESTION IN DESIGNING A PROSPECTIVE SYSTEM, AS CORRECTLY INDICATED BY DHHS, IS THE SELECTION OF THE UNIT OF PAYMENT. THE PROPOSAL BEFORE YOU IS TO PAY PROSPECTIVELY FOR ADMISSIONS DIVIDED INTO THOSE DIAGNOSTIC-RELATED GROUPS (OR DRGs) FOR WHICH HCFA HAS AN ADEQUATE NATIONAL SAMPLE OF CASES. PEOPLE WHO GO TO THE HOSPITAL ARE CONCERNED ABOUT THEIR TOTAL CHARGE, NOT ABOUT THE CHARGE FOR EACH INDIVIDUAL SERVICE OR FOR EACH DAY OF CARE. TWO DAYS AT $300 PER DAY IS PREFERABLE TO THREE DAYS AT $250 PER DAY. IN MARYLAND WE HAVE FOUND THAT HOSPITALS CAN CONTROL LENGTH OF STAY AND IT IS APPROPRIATE FOR MEDICARE TO ADOPT A PAYMENT UNIT WHICH ENCOURAGES LENGTH OF STAY CONTROL. THUS, THE CASE-MIX ADJUSTED ADMISSION IS MUCH SUPERIOR TO THE PATIENT DAY.

THE PROBLEM, OF COURSE, IS THAT HOSPITALS TEND TO PROVIDE MORE OF WHATEVER UNIT IS BEING PURCHASED. THEREFORE, YOU SHOULD REJECT THE PROPOSAL OF A 100% VARIABLE COST FOR ADDITIONAL ADMISSIONS AND SET A PAYMENT FORMULA WHICH PROTECTS MEDICARE FROM UNNECESSARY ADMISSIONS. DO NOT RELY SOLELY UPON PROs. FURTHER, THE ADMISSION SYSTEM SHOULD NOT PAY SEVERAL TIMES FOR THE SAME COURSE OF TREATMENT, EITHER BECAUSE OF INTER-HOSPITAL TRANSFERS OR BECAUSE OF RE-ADMISSIONS. WHILE MEDICARE'S HOSPITAL DISCHARGE DATA SET DOES NOT IDENTIFY WHETHER A PATIENT HAS BEEN DISCHARGED TO ANOTHER HOSPITAL OR RE-ADMITTED FOR THE SAME DIAGNOSIS, MEDICARE'S SUBSCRIBER RECORDS MAINTAIN DATA ON WHAT IS REFERRED TO AS A "SPELL OF ILLNESS." I PROPOSE THAT THE HOSPITAL PORTION OF ONE "SPELL OF ILLNESS" SHOULD BE THE PAYMENT UNIT WITH MULTIPLE ADMISSIONS SHARING THE PAYMENT FOR THAT ONE COURSE OF TREATMENT. AT A MINIMUM, SOME PROTECTION IS NEEDED AGAINST INTER-HOSPITAL TRANSFERS. THESE OFTEN MAKE MEDICAL SENSE BUT THEY DO NOT MAKE FISCAL SENSE IF BOTH HOSPITALS RECEIVE A FULL DRG PAYMENT. YOU SHOULD ALSO NOTE THAT SEVERAL STATES, INCLUDING MARYLAND, HAVE A MUCH RICHER DATA BASE THAN MEDICARE. THESE DATA BASES INCLUDE 100% OF MEDICARE DISCHARGES, HAVE ENOUGH DATA TO USE ALL DRG'S, AND CAN IDENTIFY TRANSFERRED AND RE-ADMITTED PATIENTS. THUS, IT MAKES SENSE FOR HCFA TO CONSIDER USING THESE DATA BASES TO DO STUDIES AND TO ALLOW THOSE STATES TO USE THEIR SUPERIOR DATA BASES FOR MEDICARE PURPOSES.

WITH REGARD TO THE QUESTION OF CASEMIX ADJUSTMENTS, I ALSO AGREE THAT DHHS CHOSE WISELY WHEN THEY SELECTED THE NEW DRGs AS THE NATIONAL CASEMIX MEASURE. THEY ARE THE BEST OF THE CURRENTLY AVAILABLE CHOICES.

HOWEVER, ONE MAJOR ADVANTAGE OF PAYING BY THE ADMISSION IS TO INVOLVE THE MEDICAL STAFF. IN SOME HOSPITALS, AN ALTERNATIVE CASEMIX GROUPING MAY FIT BETTER WITH THE MEDICAL STAFF ORGANIZATION. STATES WHICH WANT TO TAKE ADVANTAGE OF THAT SITUATION SHOULD BE PERMITTED TO DO SO.

IN ADDITION TO SUPPORTING THE CHOICE OF PAYMENT METHOD AND THE CHOICE OF PAYMENT UNIT, I BELIEVE DHHS IS CORRECT IN SEEKING TO APPLY THE SYSTEM ONLY TO SHORT-TERM HOSPITALS. THE SYSTEM, HOWEVER, SHOULD BE APPLIED TO NEW HOSPITALS AS WELL AS OLD. THE P.P.S. RATES ARE MARKET CONSTRAINTS ANALOGOUS TO THE MARKET PRICES WHICH NEW FIRMS MUST MEET IN COMPETITIVE INDUSTRIES. THERE ARE FEW LOCATIONS IN THIS COUNTRY WHICH REALLY NEED ADDITIONAL HOSPITALS. YOU SHOULD ALSO BE VERY CAREFUL NOT TO PERMIT A SITUATION IN WHICH SOME HOSPITALS IN A COMMUNITY ARE BEING PAID PROSPECTIVELY WHILE OTHERS ARE STILL BEING PAID ON A RETROSPECTIVE BASIS. THE 100% VARIABLE COST ADJUSTMENT WHICH IS SUGGESTED IN THE MEDICARE PROPOSAL WILL GIVE 100% MARGINAL REVENUES FOR ADDITIONAL ADMISSIONS IN PROSPECTIVELY PAID HOSPITALS WITHOUT REQUIRING RETROSPECTIVELY PAID HOSPITALS TO REDUCE COSTS WHEN THEY LOSE PATIENTS. WITHOUT A MODIFICATION OF THIS APPROACH, YOUR PAYMENTS MAY ESCALATE SUBSTANTIALLY BECAUSE OF UNNECESSARY ADMISSIONS AND PATIENT-SHIFTING AMONG LOCAL HOSPITALS.

IN ADDITION TO SUGGESTING THAT YOU ADOPT A VOLUME ADJUSTMENT DESIGNED TO ENCOURAGE LOWER UTILIZATION, I WOULD PROPOSE SOME OTHER TECHNICAL ADJUSTMENTS WHICH MAY HAVE A SIGNIFICANT FINANCIAL IMPACT. THE PROPOSED P.P.S. SYSTEM INCLUDES A "PASSTHROUGH" OF CAPITAL COSTS. WHILE MORE THOUGHT IS NEEDED TO DEVELOP A PROSPECTIVE SYSTEM FOR THE CAPITAL COSTS ASSOCIATED WITH BUILDINGS AND FIXED EQUIPMENT, A PROSPECTIVE SYSTEM FOR

MOVABLE EQUIPMENT COULD BE ADOPTED AT THIS TIME. I HAVE ATTACHED A PROPOSED MARYLAND POLICY ON EQUIPMENT AS AN APPENDIX TO MY REMARKS. FUTHER, YOU SHOULD SET A LIMIT TO THE POTENTIAL COST IMPACT OF CAPITAL PROJECTS WHILE A LONG TERM PROSPECTIVE SOLUTION IS BEING DEVELOPED. PERHAPS SECTION 223 TYPE LIMITS ON CAPITAL COST COULD BE ADDED TO PROSPECTIVE PAYMENTS FOR OPERATING COSTS. HOSPITALS SHOULD BE PERMITTED TO SELECT THEIR OWN MIX OF LABOR AND CAPITAL IN THE PRODUCTION OF PATIENT TREATMENTS WITHOUT A CHANGE IN PAYMENT FOR THE PRODUCT. THE ROCHESTER AREA HOSPITAL CORPORATION, IN ROCHESTER, NEW YORK -- A SYSTEM WHICH OPERATES UNDER A MEDICARE WAIVER -- HAS BEGUN EFFORTS TO DEVELOP A PROSPECTIVE PAYMENT SYSTEM FOR CAPITAL. THEY, TOO, ARE CONCERNED THAT A PASSTHROUGH CAPITAL SYSTEM DOES NOT CONSIDER AFFORDABILITY OR ENCOURAGE PRUDENT FINANCING OF HOSPITAL CAPITAL STOCK.

A SECOND CONCERN IS THE CONTINUATION OF COST-BASED PAYMENT FOR HOSPITAL OUTPATIENT ACTIVITIES. ONE OF THE LESSONS OF MARYLAND AND MANY OTHER STATES IS THAT THE ALLOCATION OF COSTS IS AN ART RATHER THAN A SCIENCE. HOSPITAL FINANCIAL OFFICERS ARE ADEPT AT THE ART OF ALLOCATING COSTS WHERE THEY WILL GET PAID. THE POTENTIAL FOR SHIFTING COSTS FROM INPATIENT TO OUTPATIENT IS ENOURMOUS ESPECIALLY SINCE THE CURRENT PAYMENT SYSTEM TENDS TO ENCOURAGE OVERALLOCATIONS TO INPATIENTS. HOSPITALS ARE ALREADY MUCH MORE COSTLY PROVIDERS OF OUTPATIENT CARE THAN NON-HOSPITAL PROVIDERS OF SIMILAR SERVICES. THIS PROVISION WILL ENCOURAGE HOSPITALS TO OPEN OR EXPAND WHERE THEY SHOULD BE CONTRACTING. I PROPOSE THAT A SECTION 223 TYPE LIMIT OR PROSPECTIVE LIMIT ON OUTPATIENT SERVICES BE ADOPTED WITH THE STANDARD OF REASONABLENESS KEYED TO THE COST OF NON-HOSPITAL PROVIDERS. A SPECIAL PROVISION CAN BE MADE FOR THE SPECIALIZED CLINICS

OF TEACHING HOSPITALS. IT IS IMPORTANT TO REMEMBER THAT COMMUNITY SERVICES DO NOT DEVELOP IN THE SHADOWS OF HOSPITAL OUTPATIENT DEPARTMENTS, AND THAT FAILURE TO CONTROL HOSPITAL COSTS REDUCES THE FUNDS FOR SOCIAL SERVICES TO THOSE POPULATIONS OSTENSIBLY PROTECTED BY HOSPITAL OUTPATIENT DEPARTMENTS.

MY THIRD CONCERN RELATES TO THE ADJUSTMENTS FOR TEACHING HOSPITALS. THE PROPOSAL CONTAINS TWO ADJUSTMENTS FOR TEACHING HOSPITALS -- A DIRECT COST ADJUSTMENT TO REFLECT THE COST OF INTERNS AND RESIDENTS AND AN INDIRECT COST ADJUSTMENT TO REFLECT THE MORE COSTLY MEDICAL PRACTICES WHICH ARE ASSOCIATED WITH MEDICAL EDUCATION. IN FACT, THE DIRECT SERVICES OF RESIDENTS AND INTERNS ARE OFTEN A BARGAIN FOR THOSE WHO RECEIVE THEM. IT IS NOT PATIENTS WHO ARE SUBSIDIZED BY THESE SERVICES AND PAYMENTS; INSTEAD, IT IS ATTENDING PHYSICIANS, WHO OFTEN RECEIVE THEIR FULL PAY WHILE SHIFTING MUCH OF THE BURDEN OF CARE TO THE RESIDENTS, WHO ARE SUBSIDIZED. MUCH THE SAME CAN BE SAID FOR FULL-TIME PAID NON-RESIDENT HOUSE STAFF. P.P.S. SHOULD MAKE AN ADJUSTMENT FOR REAL TEACHING ACTIVITIES AND FOR MEDICAL SERVICES BUT SHOULD BE WARY OF PAYING FOR THE SAME SERVICE UNDER MEDICARE PART A AND PART B.

ACCORDING TO THE DHHS PROPOSAL, THE INDIRECT COST ADJUSTMENT IS BEING MADE BECAUSE TEACHING HOSPITALS DO MORE ANCILLARY TESTING AND KEEP PATIENTS FOR LONGER PERIODS. THE DEPARTMENT'S CONCERN IS THAT THEIR DATA BASE CANNOT DISTINGUISH THE DIFFERENCE IN SEVERITY WITHIN DIAGNOSTIC GROUPS FROM SIMPLE INEFFICIENCIES. OUR MAJOR TEACHING HOSPITALS DO NEED PROTECTION FROM UNADJUSTED DRG PAYMENTS. THEY ARE SUBJECT TO A MORE INTENSE PATIENT MIX AND THE SYSTEM OF HOSPITAL CHARGING REQUIRED BY MEDICARE AND

THE BASIS FOR DRG RELATIVE PRICES WORKS AGAINST THEM. ALL PATIENTS ARE CHARGED THE SAME AMOUNT PER DAY FOR ROUTINE SERVICES UNLESS THEY ARE IN INTENSIVE CARE. MOST HOSPITALS ALSO CHARGE SIMILAR AMOUNTS FOR TIME IN THE OPERATING ROOM, REGARDLESS OF WHETHER A SIMPLE OR COMPLEX PROCEDURE IS BEING PERFORMED, SIMILAR EXAMPLES EXIST IN OTHER DEPARTMENTS. THUS, TEACHING HOSPITALS ROUTINELY OVERCHARGE SIMPLE CASES AND UNDERCHARGE VERY COMPLEX CASES. THE PROPOSED SYSTEM, IF UNADJUSTED, WOULD NOT PAY THEM THE OVERCHARGE FOR ROUTINE CASES BECAUSE THE NATIONAL AVERAGE SAMPLE CONTAINS MANY HOSPITALS WHICH ONLY PERFORM ROUTINE SERVICES AT UNINFLATED COSTS. SINCE ALMOST EVERY HOSPITAL WHICH PERFORMS COMPLEX SURGERY UNDERPRICES THAT SURGERY, THE AVERAGING METHOD WILL ASSIGN TOO LOW A RELATIVE PRICE FOR COMPLEX CASES. NEW YORK, NEW JERSEY AND MARYLAND -- ALL STATES WITH PROSPECTIVE RATES -- HAVE DEVELOPED OR ARE DEVELOPING DRG-RELATED NURSING CHARGES AS AN IMPROVEMENT UPON UNIFORM ROUTINE CHARGES.

MY FINAL OBSERVATION REGARDS THE TREATMENT IN THE P.P.S. OF WAGE RATES. FIRST, THE DHHS HOSPITAL MARKET BASKET HAS HISTORICALLY MEASURED THE RATE OF INCREASE IN HOSPITAL WAGES. THUS, IF HOSPITAL WAGES INCREASE MORE RAPIDLY THAN OTHER WAGES, THAT HIGHER RATE OF ESCALATION IS PASSED THROUGH INTO HOSPITAL PAYMENTS. HOSPITAL WAGE RATES ARE NO LONGER LOWER THAN WAGES IN COMPARABLE POSITIONS AND THEIR INFLATION SHOULD BE NO MORE THAN GENERAL WAGE RATE INCREASES, ESPECIALLY WHEN THEY ARE PASSED THROUGH WITHOUT REQUIRING PRODUCTIVITY INCREASES. SEVERAL NON-HOSPITAL WAGE INFLATION INDICES COULD BE USED IN PLACE OF HOSPITAL WAGE EXPERIENCE. MARYLAND USES THE RATE OF INCREASE IN AVERAGE HOURLY EARNINGS OF PRODUCTION OR NON-SUPERVISORY WORKERS IN SERVICE INDUSTRIES TO SET REASONABLE STANDARDS

FOR HOSPITAL WAGE INCREASES. WHY SHOULD THE MEDICARE PART A FINANCE WAGE INCREASES WHICH ARE HIGHER THAN THOSE WHICH CAN BE ABSORBED IN OTHER PARTS OF THE FEDERAL BUDGET?

THE SECOND WAGE-RELATED PROBLEM IS THE MATTER OF HOW TO MAKE WAGE RATE ADJUSTMENTS FOR HOSPITALS IN DIFFERENT LABOR MARKETS. THIS IS IMPORTANT BECAUSE WAGE RELATED COSTS AMOUNT TO 80% OF HOSPITAL COSTS. (P. 87). THE DHHS PROPOSAL STATES, ON PAGE 44, THAT THE WAGE RATE ADJUSTMENT WILL BE "BASED UPON HOSPITAL WAGE INFORMATION." THIS IS A GREAT IMPROVEMENT OVER THE PREVIOUS SYSTEM OF USING AREA PER CAPITA INCOMES TO ADJUST HOSPITAL WAGE LEVELS. HOWEVER, IT SHOULD BE NOTED THAT SOME AREAS MAKE SUBSTANTIALLY GREATER USE OF PART-TIME EMPLOYEES THAN OTHERS AND THAT A COMMUNITY'S JOB MIX VARIES MUCH MORE THAN HOSPITAL JOB MIXES. ACCORDING TO THE PROPOSED DHHS SYSTEM OF WAGE ADJUSTMENTS, HOSPITALS IN ROCHESTER, NEW YORK WOULD GET A NEAR AVERAGE WAGE FACTOR BECAUSE OF THE LOCAL MIX OF EMPLOYMENT IN THESE JOBS AND THE LOCAL PATTERN OF PART-TIME EMPLOYMENT. MEANWHILE, HOSPITALS IN SYRACUSE, NEW YORK -- LESS THAN TWO HOURS AWAY -- WOULD GET A WAGE FACTOR WHICH IS 43.6% HIGHER THAN THE ROCHESTER FACTOR. I SIMPLY CANNOT BELIEVE THAT HOSPITAL WAGE COSTS ARE 43.6% HIGHER IN SYRACUSE THAN THEY ARE IN ROCHESTER. IT IS NOT APPROPRIATE TO GO TO THE REFINEMENT OF USING 356 DRGs TO STRATIFY CASEMIX WITHOUT DOING A BETTER JOB OF MAKING JOB-MIX ADJUSTMENTS FOR THE PURPOSES OF COMPARING LABOR COSTS. STATES WITH MEDICARE WAIVERS HAVE DEVELOPED USEFUL METHODS OF PERFORMING MORE SOPHISTICATED ADJUSTMENTS.

FINALLY, I WOULD LIKE TO SAY THAT THE MARYLAND COMMISSION HAS WORKED CLOSELY WITH HCFA'S OFFICE OF RESEARCH AND DEMONSTRATIONS AND WITH THEIR

OFFICE OF RESEARCH. BOTH THESE OFFICES ARE STAFFED WITH SEVERAL HIGHLY COMPETENT INDIVIDUALS WHO COULD CORRECT THE TECHNICAL PROBLEMS WHICH I HAVE HIGHLIGHTED IN THIS TESTIMONY.

IN SUMMARY, IT IS MY OPINION THAT HOSPITAL COSTS ARE RISING FAR TOO RAPIDLY AND THAT PROSPECTIVE, INCENTIVE-BASED MEDICARE PAYMENTS WILL BE A GREAT IMPROVEMENT OVER RETROSPECTIVE COST REIMBURSEMENT. CONGRESS SHOULD ALSO ENACT CHANGES IN THE TAX LAWS GOVERNING THE HOSPITAL MARKET PLACE WHICH WILL PREVENT COST SHIFTING. STATES SHOULD BE ALLOWED TO ADOPT ALL PAYOR SYSTEMS WHICH MEET FEDERAL PERFORMANCE CRITERIA, PROTECT ALL PAYORS, AND CONSTRAIN TOTAL HOSPITAL RESOURCE USE. CONGRESS SHOULD ALSO MAKE SOME TECHNICAL CHANGES IN THE DHHS PROPOSAL BEFORE ADOPTING IT.

THANK YOU. I SHALL BE PLEASED TO RESPOND TO QUESTIONS.

PROPOSED POLICY ON EQUIPMENT

The Commission staff proposes that the Commission adopt a policy in regard to hospital equipment costs and the treatment of rate requests involving equipment purchases. The purpose of the policy is to set in place the appropriate incentives for hospitals to make proper business type decisions in their equipment purchases and to assure that hospitals have appropriate funds with which to purchase equipment. There are three underlining hypotheses which guide the proposed policy. The first hypothesis is that in the provision of health services, labor and capital is often interchangeable. Hospital production can be carried out with significantly different capital labor ratios. The second hypothesis is that hospital management should have the opportunity to choose for themselves the mix of capital and labor which they wish to use to produce hospital output and that that business decision should not influence the rates that can be charged for the patient care promoted. The third hypothesis is that the principal output of hospitals is the treatment of patients with specific ailments.

The proposed policy on equipment takes two parts. The first part relates to policies regarding rate applications and equipment expenditures, and the second part involves proposed changes in the calculation of full financial requirements as they relate to cash needs for equipment.

A. The proposed policies regarding rate requests for equipment.

1. The first distinction the staff would make is between replacement equipment and new equipment. The staff proposes that replacement equipment should have no impact upon the rates of a hospital because the hospital's rates already include replacement cost depreciation. The reason for

providing replacement cost depreciation for capital is this provides the hospital with sufficient funds to purchase replacement equipment with cash. Hospitals may, for wise business purposes, take advantage of attractive financing opportunities made available by their tax exempt status, but the interest they pay on such borrowings should be at least off-set by the earnings they receive on the non-expended replacement depreciation funds.

2. The second distinction the Commission staff would propose is between business equipment and patient care equipment. Business type equipment involves such things as computerized management information systems, word processing, and equipment associated with hotel type functions of the hospital. This equipment is not used directly for the provision of patient care. The Commission staff would propose that no change in rates be made for the purchase of business type equipment since such equipment should pay for itself through efficiencies. It may be appropriate in an individual circumstance that a hospital, for cash flow purposes, needs an advance on the purchase of such equipment, but in such a case the public should get a pay-back at least equal to the interest rate then in use in the Commission's inflation adjustment system. A hospital which purchases business equipment with its own funds would be entitled to all the savings that that purchase generates, but a hospital which uses public funds would be expected to allow the public to realize a return on the use of those funds.

The next distinction the Commission staff would make is between individual patient care equipment which is used to provide the same services as existing equipment and personnel versus equipment which is used to provide new services. In many cases the first type of equipment purchase is similar to business equipment.

The question of whether to perform laboratory tests with the use of sophisticated equipment or with the use of sophisticated technicians is a choice which hospitals should make without increasing their revenue or decreasing their revenue. The Commission staff believes that decisions within existing departments to substitute equipment for labor or to purchase additional equipment should not result in rate changes.

Equipment that provides new services should also be divided into two categories. The first relates to services which provide care for illnesses in a different way than they were provided previously and the second are those which provide care for illnesses which the hospital did not previously treat. Examples of the latter would appear to be such things as renal dialysis equipment and radiation therapy equipment. Where the planning agency finds that it is appropriate for a hospital to provide this additional service, then the Commission staff believes that this additional service should result in revenue to the hospital above the simple impact of inflation. Where a hospital chooses to provide the same output through its use of a different mix of departmental inputs, the Commission staff believes that this should not result in additional revenue to the hospital. Some examples of this is the inpatient use of CAT scanners and ultrasound. In both cases, the Commission would approve new departmental rates, but new revenues would not be appropriate except under unusual circumstances. Of course, the GIR provides new service dollars which would not be duplicated.

Finally, it is worth noting that the Commission staff does not believe that the Commission should make any distinction between relatively expensive equipment and relatively inexpensive equipment. The State Health Planning Law establishes a threshold for the purchase of hospital equipment such that hospitals require planning approval to purchase a piece of equipment costing over $400,000 or related pieces of equipment which cost over $400,000 in the aggregate. From the rate review prospective it should make no difference whatever whether a hospital chooses to buy three $200,000 pieces of equipment or one $600,000 piece of equipment out of its equipment budget in a particular year. The purchase of a $600,000 piece of equipment, while requiring planning approval, is not supplementary to, but rather an alternative to, purchase of the three $200,000 pieces of equipment which do not require planning approval. Thus, the Commission should make no distinction in its treatment of equipment based upon whether it is expensive or inexpensive.

Since replacement equipment and business equipment may be quite costly and the expenditures may not be even over time, the Commission may wish to adjust the hospitals equipment flow to reflect the needs when large purchases are to be made. Thus, a hospital with an equipment budget of $800,000 a year which gets planning approval to spend $1 million on one piece of equipment could receive an adjustment in rates which recognizes a cash flow, say, of $1,200,000 the first year and $600,000 the next two years so that at the end of three years the hospital would have received the same total amount of dollars.

Essentially, the above policies propose that hospital equipment be treated as much as possible as business type decisions of hospitals where patients pay according to the illness the hospitals treat and hospital managment has the appropriate incentives to provide those services in an efficient manner.

B. Related policies regarding full financial requirements for equipment.

The institution of the above policy should also be accompanied by the institution of what the Commission staff believes is a more appropriate and current determination of the relationship between equipment and financial needs.

1. The staff belives that hospitals should be free to decide how to produce laboratory tests without that decision having any impact on the charges of the hospital. The Commission's current system does not have that property. The Commission's departmental statistic in the laboratory is not interdependent of the way in which a laboratory test is performed. The Commission staff is proposing that the statistics be changed so that hospitals only use the relative value measure associated with manual production of tests. Thus, if a hospital shifts to use of equipment, it will not receive less money by assigning the test fewer relative value units.

2. The general equipment allowance used by the Commission derives from actual equipment expenditures reported in Medicare cost reports prior to the Commission's beginning of rate setting. This amount has been inflated over time. Since that time hospitals have had ample reason to substitute capital for labor and the Commission system has not reflected that substitution. The Commission staff recommends that the Commission establish a new base for the general equipment allowance by doing a new audit similar to the original one.

3. The specific equipment allowance associated with capital intense departments has been maintained on a current basis but several hospitals have shown that they did not correctly report the value of equipment

which was fully depreciated prior to their original rate setting. Thus, their replacement depreciation flow has, in some cases, not been adequate to finance replacement equipment. Most hospitals base has been adjusted by now to correct for their original reporting error. The Commission uses a depreciation cycle of 10 years for all equipment except for CAT scanners in which the Commission uses 6 1/2 years. The Commission staff proposes that an audit be made to determine how much the equipment allowance would have to be increased to reflect current lives approved by Medicare and that such an adjustment be made to the departmental equipment allowance for each hospital.

While all these adjustments will provide additional dollars for the hospital industry, the staff believes they are appropriate and will put equipment decisions on a sound financial basis from which hospitals should be financially responsible for their own equipment decisions except for cases in which new patient care outputs are being provided.

Finally, the Commission staff would indicate that two aspects of the inflation adjustment system regarding equipment should also be considered. Currently, the weight used in the inflation adjustment system regarding labor is based upon the hospitals actual labor expenditures as reported in their most recent rate review system while the equipment weight is based on the equipment approved by the Commission. Therefore, hospitals which shift from labor to capital are at a disadvantage. The staff proposes that as a minimum the Commission shift to a system in which the weighting is based on the base approved percentages for capital and labor so that shifts have no influence on the hospitals revenue over time.

The Commission staff would also like the Commission to consider that an industry-wide weight be proposed for capital and equipment so that hospitals are not treated differently in regard to inflation because they have chosen to produce their services in a different manner. The Commission's staff does not have a specific position on this latter point.

MR. CHAIRMAN, IN ADDITION TO MY PREPARED COMMENTS, I WOULD LIKE TO ADDRESS THE SECTION REGARDING PART B SERVICES ON P. 49. LAST YEAR I TESTIFIED THAT TEFRA LIMITS SHOULD PROVIDE FOR REDUCTIONS IN THE BASE COST WHEN HOSPITALS LEASE OUT THE SO-CALLED "TECHNICAL" PORTION OF LABORATORY, X-RAY AND THE ANCILLARY DEPARTMENTS. THAT SUGGESTION WAS INCORPORATED IN TEFRA. I BELIEVE THE RATHER VAGUE PROMISE TO MONITOR THIS PROBLEM UNDER PPS WILL NOT BE SUFFICIENT TO PROTECT THE TRUST FUNDS FROM THIS "POTENTIALLY SERIOUS PROBLEM". DIFFERENT PROVIDERS CAN OFTEN CHOOSE DIFFERENT INTERMEDIARIES AND INTERMEDIARIES WILL BE VERY BUSY EXAMINING THE SHIFTING OF COSTS INTO PASS-THROUGH CATEGORIES - ESPECIALLY CAPITAL AND OUTPATIENT CARE. THUS, TO SOLVE THIS PROBLEM I PROPOSE THAT ONLY HOSPITALS BE PAID FOR THE "TECHNICAL" PORTION OF X-RAY, LABORATORY AND THE MEDICAL SERVICES PROVIDED INPATIENTS. LET HOSPITALS, WHICH ALLOW THESE SERVICES TO BE "CONTRACTED OUT", WORK OUT THE FINANCIAL ARRANGEMENTS WITH THE SERVICE PROVIDERS. THIS WOULD HAVE THE ADDED INCENTIVE OF MAKING HOSPITALS PRUDENT BUYERS OF THESE SERVICES ON MEDICARE'S BEHALF.

Senator **Durenberger**. One of the reasons the hospitals favor an institution-by-institution approach is because of the severity issue. I asked the question of the teaching hospitals as to where we are in trying to come up with a severity index.

The answer I got back is that while there is some work being done on a severity index, it's quite a ways from completion. Have any of the three of you had any experience with a severity index?

Mr. **Cohen**. Our experience is precisely as you described it, Mr. Chairman. Most of the work is associated with Johns Hopkins and Rockburn Institute in Maryland. University Hospital is one of the hospitals being studied in developing severity scores. I am not supporting that severity scores now be assigned across DRG's. But they do make significant differences in comparing a patient even between teaching hospitals. That is, there are significant differences in severity according to the work that is being done between the Johns Hospkins Hospital and University Hospital of Maryland. It is real. And I would say that what it does is emphasize the problems that teaching hospitals face, in part, because of the average types of costing that is associated with the Medpar data base because of the way we charge for hospitals services.

Senator **Durenberger**. Any other comments?

Mr. **Crane**. Well, in New York, the issue is not as important as it would be with a DRG system. We have tried in the development of our case mix measures, though, to use age along with diagnosis as a major way to adjust cost expectations for hospitals. And while that is not a direct measure of severity, it moves a small step in that direction.

Senator **Durenberger**. All right.

Mr. **Cohen**. Mr. Chairman, one of the things I might mention that Maryland believes is, as my statement indicates, that the selection of the admission in a case mix adjusted admission is to give the hospital incentive to respond to reducing length of stay and changing medical practice. And that one of the advantages that we have with our data base is to choose that particular definition of case mix adjustment which best helps a particular hospital organize its given medical staff to respond to those incentives. The idea is to design a system you want the hospital to beat because it saves money overall, and then helps them beat it. And I think that's an advantage that we have. And that over time with the development of a case mix data base, HCFA also will do it.

Senator **Durenberger**. There is through the written testimony of all three of you, I believe—or maybe I am confusing it in Jersey's case with Mr. Scibetta's testimony and he is not here today, a fair amount of peer review or utilization review, and health planning.

There also seems to be support for all-payers systems or an escape clause for States that want to go to all payers. I support some of these concepts such as health planning, although perhaps in a different form than some of you advocate. I would like to see more of the experiments in health planning that are being done in places like Rochester, N.Y.

But as we evaluate your testimony, the fact of the matter is that all three of you are regulators. You are not the marketplace at work out there. Your job is to regulate. And at least I, for one, want to eventually get away from regulation and move out to the marketplace. It seems to me that an all-payer system, for example, is a good regulator system rather than a marketplace system because there is one price for all of the products, and there is really no way within a pricing mechanism to determine quality or efficiency.

We heard this morning about concerns relating to quality of care, early discharge, shifting costs off onto part B, or leasing out pharmacy. The answer from providers in the marketplace was that, well, malpractice is there, efficient hospital administration is there, the PRO process is out there, and so forth. But we hear, for example, from you, Dr. Cohen, that the best approach is the regulatory approach to just put a cap on the growth in part B, or put a cap on the growth in capital cost.

If we are trying to move in the direction of a marketplace system, how can we adapt regulatory mechanisms so that they aren't stifling jobs? What can we do with capital costs and teaching costs, the all-payer system and so forth, that takes prospective payment beyond a change in reimbursement to something that will facilitate more freedom of choice in the marketplace?

Mr. COHEN. I would like to, as an example, respond in regard to the capital question. Obviously having some planning agency decide whether something is financially feasible in a system in which whatever is approved is automatically passed through is hardly a marketplace solution.

I've been recommending for years that medicare develop its own, in effect, 223 kind of rule for capital saying this is what we will pay. And then the planners, when considering financial feasibility, will be faced with what one of the payers at least has said it will pay. Right now, no payer has said what they will pay, and they act as if there is an automatic passthrough. That it is not a market system. So I would suggest that it would be appropriate for Congress to say this is what we will pay for capital, as well as the other stuff. I would think it can't be done in a prospective system at this time, but something could be done under 223, which at least does set some kind of limit as to what will happen because the planners or the marketplace then will consider how much medicare has said they will pay for certain services on a capital basis.

Mr. PIERCE. I'd just add that I think the free market system in the hospital world is always going to be quite limited, but that the DRG program, combined with all payers, does begin to get a sense of flexibility in terms of, well, how efficient can we produce one type of operation versus another or versus our competitors down the street. And while it is still too early to tell, you do find hospitals beginning to say to themselves and beginning to develop their strategy—we really do quite well in a certain array of cases. And this is something we ought to promote and be more aggressive about. And we ought to look at those cases where their costs are much higher than the revenue they are getting. So it is setting up kind of a cost sensitivity that I don't think has existed in the past, and at least has some dynamics of the free market system.

Senator DURENBERGER. And in the absence of an all payer-system you don't get that cost sensitivity because the costs are shifted from the one averaging system to the ones that don't.

Mr. PIERCE. Correct.

Senator DURENBERGER. Is that the point of your testimony?

Mr. PIERCE. Yes.

Mr. CRANE. I think the test of a more competitive system will be seen as California moves into their system. One of the characteristics of the California health care delivery system that is not prevelant in any of our systems is a lot of excess capacity. When you have excess capacity, it's easier to develop a competitive bidding process.

However, I don't think that even our systems preclude some element of competition. Certainly, hospitals through the comparison with their peers in our grouping methodology are judged on the competitive basis—that is, whether they can deliver a product at a price similar to their peers. And if they can't they face financial disincentives or penalties.

Similarly, an employer or an HMO, can adopt a prudent buyer approach by looking at the different, in our case, per diem rates and selecting hospitals which can deliver at a lower cost. And so they can channel patients. Systems of care can channel patients to hospitals which are less costly even within a regulated system.

Senator DURENBERGER. Thank you. Senator Baucus.

Senator BAUCUS. Can you tell me, based upon your experience in the area and also representing States that have some form of DRG payment, looking at the Administration's proposal, what are the greatest areas of potential abuse?

Mr. COHEN. I would think that the potential areas are in volume.

Senator BAUCUS. Volume meaning what?

Mr. COHEN. The ability to take advantage by doing things on an inpatient basis which have been shifted to outpatient. The outpatient matter that I raised earlier, I think, is quite a significant cost potential. And I wouldn't describe it as a regulatory proposal to limit outpatient costs. Primarily what I would recommend is that medicare take advantage of what it said medicaid could do last year. That is, say that hospitals should be paid on the basis of what it costs nonhospitals to provide some of those services.

And, of course, I'm concerned to some extent about the possibility of leasing as a way to avoid some of the service costs that are now in the inpatient basis. As I also indicated, we have been using as an inflation factor for labor a hospital labor inflation. And that's a very big money question. That is, what should the labor inflation factor be in developing the rate of escalation under whatever system you use, whether it be TEFRA, whether it be this, whether it be anything. And I would suggest that hospital employees are no longer underpaid compared to the rest of the economy, and you should be thinking very carefully before you decide that medicare part A should be paying 8–9 percent wage increases when the rest of the Federal Government and the rest of most social services can't afford to pay hardly anything at all.

Senator DURENBERGER. Do the other two have any comments?

Mr. CRANE. I would see three major issues, and Hal has touched on several of them. One is unbundling. Taking costs and moving them out of the controlled reimbursement system. Second is cost shifting as opposed to cost containment. In essence, not making changes in management as you would be forced to do in an all payer system, but rather just shifting costs to others payers.

Finally, in any system that you set up, you get what you pay for. In this case, you are setting up a system where you are paying for admissions or cases, and you are likely to get more admissions and cases under this system. And so it gets back to one of the earlier points that if you are going to move in this direction, you need a strong utilization review system to offset that incentive.

Mr. PIERCE. I basically agree with Hal and Bob. And what they have pointed out are the key problems. We would only suggest that it is important to have a monitoring device over quality, and one to make sure that you are not getting false admissions. This probably means that the monitoring organizations have to move in a different direction than what they have been doing in the past. Or to a statistical analysis where you can monitor the trends of what is happening to DRG's by hospitals, and less labor intensive kind of quality assurance.

Senator BAUCUS. You are anticipating my next question, which was how do we prevent this occurring? I suppose monitoring would help in some fashion, but cost shifting and other potential abuses probably would not be cured so much from monitoring as they can by moving to an all payers system or changing the tax structures and so forth. Do you have any other suggestions on how we correct those potential abuses? Do you recommend going to all payers?

Mr. COHEN. I think you should allow States that want to go to all payers to go to all payers. But I think that across the country as a whole you should enforce the likelihood that the market will act like a market by changing the tax laws, as the No. 1 step.

Mr. PIERCE. I would certainly encourage you to allow waivers to any State that wants to move and has the capability and interest. New Jersey did start, essentially, with a single payer—Blue Cross—and built up some years of experience, which was highly valuable, before moving into all payers.

Senator **Baucus**. What's your reaction to letting payers compete among themselves? Telling their beneficiaries, look at all the great benefits given you.

Mr. **Cohen**. Competition can take place between the patient and the hospital or between the payer and the hospital. And I think most experience suggests that when patients are ready for hospital care, that is not the best time to hope that the market will work. And I would tend to suggest that the changes should be directed toward making that other market work. That is, the market between the payers and the hospital.

Mr. **Pierce**. I would agree that you have a problem once you get that kind of heavy competition and you may drive the excess—as you probably will in California—out. And then you have a semimonopoly again.

Senator **Baucus**. Thank you.

Senator **Durenberger**. Senator Bradley.

Senator **Bradley**. Thank you, Mr. Chairman.

What kind of data do you think that we should make sure is collected by the DRG system? And what kind of feedback would be helpful to the hospitals?

Mr. **Pierce**. You mean the kind of data that medicare should be collecting?

Senator **Bradley**. That is correct.

Mr. **Pierce**. First it needs cost reports. And New Jersey as been able to use the cost reports and the uniform bill, as well as then checking against the audited statement that the hospital files. I would say that it has taken a great deal of time, and I wish we had been able to do more education on how to fill out the uniform bill. As your question suggests, clean data is absolutely essential when you come to final pay out, and then even later the reconciliation.

Mr. **Cohen**. Senator Bradley, I believe that Mr. Owen's testimony earlier was excellent. That is, we have found that physicians do, indeed, respond when they get information about what is going in their hospitals as regard to style of medical practice. Especially in our area in the East, that is a major cost question—the length of stay. And that behavior changes. And I think it is important that hospitals not only collect the uniform hospital discharge data, but that is made available to them through the hospitals on a physician specific basis so that they can use that to let the individual physicians know who is costing the money. But this would be something that the hospitals would be able to generate from the data base.

Senator **Bradley**. Do you feel that provision of such data feedback would result in physicians competing for the shortest length of stay for their patients in the hospital?

Mr. **Cohen**. I think it would be physicians being more aware whereas their individual practice differs from their peers in a way that costs the hospitals money. I don't think they would try to become the shortest, but I think if they started out being quite high—and experience suggests that where hospitals have a high length of stay, it is usually four or five admitters in the hospital and not the whole medical staff. And getting the information to those four or five admitters has a very big impact on the cost to the hospital. And that can be done with this data base.

Mr. Crane. If you are going to create change here, you have to create change on the part of physicians because they are primarily responsible for the generation of costs. And one of the major advantages of a DRG per case system is to use the kind of data that a hospital would get to identify outliers, and that information, I think, alone will help physicians themselves identify who among them are causing the hospital problems.

Senator Bradley. Do you mean which physicians are responsible for the largest percentage of outliers?

Mr. Crane. That's correct. That fall outside the norm. In essence, DRG's are causing the hospital to lose money. And it seems to me that the board of trustees of the hospitals, the hospital administrator, the medical staff organization can use such information in positive ways.

Again, the incentive would be greater if the system includes all payers as opposed to medicare only. But I think it would be positive here as well.

Senator Bradley. You might share with the committee the New Jersey experience on adjustment for technology changes. How do we factor for technology?

Mr. Pierce. Basically, the adjustment for technology is incorporated in two major ways at the moment. One is through the certificate of need process. And certainly in New Jersey we have found that to be valuable. And that's the way you do get a chance to review the new technology that is coming in. New technology gets approved for a certificate of need, and then goes to rate setting for the specific reimbursement amount.

The second is a more complex one. It's what we call a DRG clinical appeal where a claim is made that the treatment modality has changed in such a way that it will increase costs. And this is presented to a physician review panel. And then that would be additionally added into the rates.

In addition, eventually in New Jersey we will be rebasing. Currently we are using a 1979 base for the current rates; we will be moving to a 1982 base. When you rebase, you have a tendency to incorporate many of the new treatments.

Senator Bradley. Under the proposal that we are considering, I think it says that HCFA would allow only one-half of 1 percent for outliers. In New Jersey, we have had a much bigger percent for outliers. Do you think that the HCFA target is an unrealistically low number? How might it affect the different kinds of hospitals if we did keep this level of cap?

Mr. Pierce. Based on our experience, we've had closer to 30 percent, 32 percent, outliers. And one-half of 1 percent does seem unrealistically narrow.

Senator Bradley. What about your experiences in New Jersey. If the current experiments show that there are 30 percent outliers, how could anyone come in and suggest that we have outliers limited to one-half of 1 percent? What is the evidence that would lead one to believe that you could get by with one-half of 1 percent? Not in New York and Maryland, right? [Laughter.]

Mr. Crane. I think it's down Independence Avenue somewhere.

Mr. Morris. There are other instances that would increase that one-half of 1 percent, and it doesn't come out in the HHS proposal.

The one-half of 1 percent, I believe, are the high outliers for length of stay. There are 74 DRG's which are considered clincial outlier groups and all of those patients would be outliers. In New Jersey we also count as outliers patients who die, patients who leave against medical advice, and also cases for which the hospital has a low volume of patients. If a hospital has less than five patients in any DRG in a year, we don't believe that they have the statistical base to really have an average cost, so we also consider those patients as outliers.

I think the one-half of 1 percent appears low since we have approximately 9 percent high length of stay outliers in New Jersey.

Senator **Bradley**. Even with those definitional exceptions?

Mr. **Morris**. Right.

Senator **Bradley**. Is the time up, Mr. Chairman?

Senator **Durenberger**. Yes; if you have another question, go ahead and ask it.

Senator **Bradley**. Well, I just wanted to get your sense, and you did talk about it a little bit earlier today whether the administration was in favor of an all payer or single payer system. They said that they would like to leave the States with the option. They then argued that there would be this competition out there among various insurance companies. Is it your sense that this will occur? Would you prefer to have a State option or do you think it should be all payer national system? This brings us back to what Senator Durenberger questioned, competition versus regulation.

Mr. **Cohen**. I was not recommending an all payer as a national solution. But that if individual States wished to use all payers, that be allowed. I would actually recommend that you choose a prudent one for medicare, and put in place the market changes to get the other buyers to act as prudent buyers for themselves.

We have tried in Maryland, and have seen, as Bob Crane indicated, a considerable amount of activity on the part of insurance companies and others to encourage shopping, to design purchasing per admission review and things of other sorts to try to act prudently within the context of the rate system in Maryland.

Mr. **Pierce**. That was the thrust of our comments. States should be allowed to make the choice. If you imposed it from HCFA, you would wind up with HCFA having to set rates for everyone.

Mr. **Crane**. I think that there are major problems in developing an all payer system nationally, although I don't think it should be discarded because I think it's the only way to deal with some of the cost shifting problems that we have described. Certainly, I would recommend that any bill that the committee developed encouraged States to go in that direction. And that would mean changing existing HCFA policy which requires that a State like New York has to save an additional 1½ percent under the national average for their system.

We believe that we should be held to a test of the average increase in medicare costs. We should be expected to beat the national average increase. But we shouldn't have to do better.

Senator **Durenberger**. As I recall, testimony we had last summer from some physicians, particularly those that practice in prepaid groups, identified the danger in a DRG system that doesn't provide anybody with any incentives to keep hospital use down.

They weren't testifying against the DRG system, but they didn't see appropriate incentives in an all-payer kind of system. Sure, it is great for the insurance companies. But insurance companies aren't doing anything to leverage a reduction in the cost of hospital care in a specific sense. I don't mean that as a pejorative of the health insurance industry.

So one of the statements I made to the American Hospital Association the other morning—the one where they started to get up in the back of the room and leave—was that we are going to eventually eliminate, hopefully, the distinction between part A and part B, and we will just make one payment covering all services. After all, it's the physician, as you have indicated, who dictates the degree of service, the quality of service, and to some extent the price of that service.

Let me just ask your reaction to the appropriateness of eventually moving to that kind of a system. And if we move the whole country to all-payers system in the meantime, does this slow down the process of getting to a single spell-of-illness payment?

Mr. **Crane**. The larger unit that you use to pay for care, the better incentives you have. And that's explicit in an HMO or a capitated system, which is probably the best of the cost containment systems that can be designed. So moving in the direction that you are talking about, to the extent that it moves in that direction, is good. You are then creating competition between systems of care.

I don't know that the regulatory systems in any of the three States here would preclude that from happening. But I think it should be seriously considered.

Senator **Durenberger**. I hear some of your testimony to say that your so-called regulatory system is not the ideal. It is probably transitional. It has a lot of price sensitivity, education in it. That's about the way I heard that testimony. And you are saying it would not preclude moving eventually——

Mr. **Crane**. No; I don't think so. And I think that we are constantly looking at ways to improve it, to change the disincentives and to create incentives. And certainly larger capitated systems of care are one way. And competition among those systems as you have in your home State is probably the best approach that can be designed to contain costs.

Senator **Durenberger**. Any other comments?

Mr. **Cohen**. I, too, would tend to agree that if you have a capitated system that that makes sense. I also would think there is a lot of advantages to block granting payment for health with other social services and allow communities or States choices between them. The broader the payment bases, generally the more opportunity people have to make the tradeoffs that are inherently made in the budget decisions. Those trade offs could well be to spend outside of the noncompetitive health market.

The combination of part A and part B makes a lot of sense. Right now we have a system where the managers of the system, to a large extent, have a financial advantage to shift costs onto the hospitals, and they retain their same fees. It's as if the management of a large corporation got higher wages if they could make their company be less efficient rather than more efficient. So there are very good reasons to combine as much as possible.

Senator **Bradley**. Let me just ask Mr. Pierce, if I could, one question before I have to go. And I appreciate the chance.

Today, I asked the Secretary about whether we should provide for a phase-in of either the DRG rates or the number of hospitals covered, and pointed out that in New Jersey we phased this in over a couple of years. And his response was,

> No, that is not going to be necessary. We think we can do it in 1 year because all we are going to deal with is medicare. We are not going to try to regulate the budgets of all hospitals as we do in New Jersey. Nor are we going to try to cover all payers.

So based on your experience, should the committee look at a phase-in, or do you think it is realistic to believe that we can get this all in in 1 year?

Mr. **Pierce**. Well, I think you should be sensitive to the problems of putting this in place within 1 year. We do have a dramatically different system because it includes all payers. However, we certainly found that when you phase it in, it gives people a very valuable time to learn about the system. It is complex. And you heard Mr. Owen earlier talk about the computer capabilities of small hospitals. That's very difficult. And I can't speak to the computer capabilities of HCFA, but they will have to be enormous and have to be able to respond very dramatically.

And then there is the whole question of monitoring the quality of data. And that takes a while. So I would certainly say you have a very legitimate concern.

Senator **Bradley**. I think that is probably right. Don't you? Not that I want you to tip your hand.

Senator **Durenberger**. I'm not moving my head or my eyes. [Laughter.]

Senator **Bradley**. Thank you.

Senator **Durenberger**. Thank you.

Did I cut off a response from you?

Mr. **Pierce**. I was just going to support the prepaid large base as a sound one. And would only add that we are certainly not claiming we have the ideal system, but this enormous value of a new dialog among administrators and medical staff in the hospital has led to dramatic improvements, we think, cost containment that could not have been achieved any other way.

Senator **Durenberger**. Thank you all very much for your testimony and candid responses to the question.

Our next witness will be Dr. Ron Anderson, chief executive officer of the Parkland Memorial Hospital in Dallas, Tex., on behalf of the National Association of Public Hospitals.

Welcome.

STATEMENT OF DR. RON ANDERSON, CHIEF EXECUTIVE OFFICER, PARKLAND MEMORIAL HOSPITAL, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Dr. **Anderson**. Thank you, Senator Durenberger.

Senator **Durenberger**. Your full statement will be made part of the record, and you may abbreviate it any way you desire.

Dr. **Anderson**. It's pretty hard for a boy from Oklahoma to abbreviate as much as we have to say, but we will certainly try.

Mr. Chairman, I am here on behalf not only of the National Association of Public Hospitals but also on behalf of the patients at Parkland Hospital, which is the county hospital in Dallas, Tex.

I would like to briefly summarize the overall situation of urban public hospitals in the United States today, and illustrate the problems by looking at a success story—which has been Parkland—and provide you with some comments and observations, finally, on the background of the administration's prospective proposal payment, which we think would affect urban hospitals.

In the beginning, I must say that public hospitals continue to take all patients regardless of an ability to pay. And as such, they are really the backbone, I think, of our safety net.

There have been wholesale reductions already in medicare eligibility. And in Texas, I can testify that we are the second lowest in the Nation in medicaid eligibility members. The nonmedicaid uninsured caseloads have increased substantially recently. Nonetheless, the public hospitals have really had an inflation rate that is much less than of their contemporary parts in the for-profit and nonprofit industry segments.

Public hospitals, we think, have managed the resources fairly well. In fact, it's the only segment of the hospital industry that has decreased its number of beds by 22 percent over the last decade. And we have actually decreased our length of stay. Again, the only one in the segment to do so—and turnover has improved. So we serve more patients at roughly the same cost.

Public hospitals are important providers of ambulatory care and primary care; particularly, to the inner city populations and those that don't have access to the private physician. And we have a growing body of evidence that would indicate that our patients are sicker and have more multiple diagnoses and may require more extensive resource utilization. There are reasons for that that I will get into in the summation of our talk.

Public hospitals also provide special public health and unique services to entire communities now. And we don't have a two-class system in most of the cities. And we have a burn unit department, a trauma unit, a pediatric trauma intensive care center—the first in the United States—and we try to develop services that are really not reimbursable in the classical sense because they are needed in the community.

We also have some countywide services that will be in jeopardy if we are so overloaded that we have to go back to our mandated services only. We have very small numbers of private patients now that help underwrite our charity care that will be displaced if we need to have those beds available for the charity patient. And that's really right on the doorstep.

We receive 57 percent of our revenues locally, I think somewhat putting aside the myth that the cities and the counties in the United States don't necessarily support the hospitals locally. There's a 34-percent average nationally for the members of our association. So we think that's quite good. In fact, we only receive 22 percent from medicaid, and 16 percent from medicare. In Texas, that's much lower.

Public hospitals have a high volume of services that they provide, and an intensity of care that we think is greater. And even with our local support being 57 percent, we are chronically underfunded about 10 percent. Last year, we delivered 67-percent charity care with no recourse against the patient for that money. So not only are we the backbone of the safety net, but we are also the backbone for the educational system as members from COTH, I am sure, told you this morning.

Now if I can turn a second to Parkland's story. I have been a part of the Parkland story for over 10 years as medical director and now CEO. This hospital was bankrupt in 1978. It had some sound management policies brought in—a new team, really, and was able to convince the people of Dallas to support an $80 million bond program, and also to raise taxes to support the institution and the poor in that community. And, in fact, in 1981 we finished the year with excess revenues over expenses of some $6 million.

In the last year, the increase in service demands and the volume that has brought to the institution left us with a $1.6 million redline in operating revenue. Now we did come out with a bottom line that was black, but we did so only because we had interest from our bonds, and that bailed us out. Next year, we don't feel like we can do that.

So we have been able to be classified by Moodys and Standards & Poor as a hospital that is turned around. We had the highest bond ratings of any public hospital in the United States. We shed our public image. We are not a political football anymore, but yet right now we are caught in a vise. We are doing our job, I think, well. But we have increased demand on one side, and decreased reimbursement on the other side. And as the recession and accompanying unemployment has dragged on, we have both legal and illegal aliens coming into Dallas who need medical care, and they need it at Parkland. And Parkland is the only place that won't turn them away.

We've increased from 450 a day in the emergency room to 550, peaking to 700 at times. We are seeing 900 patients a day in the outpatient clinic, which was built to see 450. Right before I came here, I stayed in the hospital until 9 and had discharge rounds to be sure we could get the people that might be worked up as an outpatient to finish up so that we would have room for the patients that were in the emergency room waiting for admission.

We've now had over 1,000 deliveries per month. That's a 14 percent increase over last year because there is commonly a $1,500 deposit for the patient who is pregnant in Texas. And there is no other resource except there. Ninety-three percent of our women last year were seen in the prenatal clinics at Parkland. Now it has dropped to 80 percent. More are coming in delivering on the doorstep.

We try to make arrangements with private hospitals to take indigent women from Dallas County who we tax support to provide for her and her high-risk neonate. And we have been successful to some degree, but we have been unsuccessful to date, and we are working to try to find out how to take care of the out of county or illegal alien patient who comes in who is not tax supported when our beds are 114 percent at capacity.

So in financial terms we do have red ink. But I think that we are doing our job, and we will be able to continue to do our job with some help, perhaps, from the nonprofit voluntary sector in our community. It may be necessary for us to go for the first time in 4 years to the county commissioners for a tax increase, but I would reemphasize that 57 percent of our money now comes from the local taxpayer. And Texas is quite unique in that regard. And one wonders how long they will be willing to pay for the total for that. As long as they are, I won't be worried about Federal policy. And I think the local control is a very important control. It's one reason that we did offer HCFA from the National Association of Public Hospitals an opportunity to go to prospective reimbursement pilots with us because we are very used to living with a prospective reimbursement system. We are very much like an HMO in some respects. We have a fixed budget. We have to live within that fixed budget, and take care of the patients who come to our door. The door is open 24 hours a day. And we don't close it to anyone.

So we thought we would be the ideal person to do that. And we agreed to do that. And right now, even because of TEFRA, we are seeing a tremendous shift of patients to Parkland, and we don't have the walls to accommodate all the patients. We won't have our new building program complete until 1985. Already an increase actually in cost is less than our volume of demand. And I think that is something we are quite proud of.

We have a long waiting list at Parkland now for elective surgery. Eighty percent of our patients come through the hospital's emergency room door to get into the hospital. And I can assure you—the typical patient who comes into large hospitals are very, very good. They admit about 20 percent of their patients through the emergency room.

The new medicare reimbursement limits under TEFRA, we really haven't had a chance to see what impact they will have on us yet. And despite a clear congressional mandate, HCFA has not yet recognized the—I guess the hospital of last resort, the hospital that deals with a disproportionate share of the poor, as being unique in some substantive ways.

So we will join with AHA; we will join with those of our colleagues who have talked about their prospective programs based upon DRG's today to suggest to you that that's the better system. That the other system that we had was a consumption system. The more you consumed, the more you could pass through, the more you made. And I have dealt with and I have lived with a system where consumption didn't mean making more money. It reduced the number of tools I had to take care of patients who had demand on my services. So we think it's a better service, but we are pretty cautious about the DRG classification because we are not only a hospital for the poor, but a hospital that has got a high level of tertiary care mix. And in that curve, that average is going to kill us, frankly, because we have developed the burn units, the transplant services, the things that nobody else developed because it was too expensive. And so we are sitting there with a group of patients that we think are going to be outliers. And we think that we will be doing a lot of appealing during this situation.

But let me give you some specifics according to the DRG's that we are concerned about. One, we would question the wisdom of Congress to employ any system that would allow massive shifts in the pay. And we think anything that didn't include something besides medicare—the medicaid all payers, in fact—would get us into that same sort of problem. Cost shifting is very real. And, particularly, it's going to affect the inner urban hospitals that take care of the poor.

And this proposal also makes no provisions for hospitals that do serve a significant member group that are low income groups.

I think it is very important to reemphasize the safety net feature of our hospitals. The NAPH has serious concerns also based upon the DRG's inaccuracy as concerns the tremendous variations that you might see in one patient, one DRG, within the same hospital.

Some of the studies mentioned by our colleagues from Maryland really came probably from Susan Horn. And within Assembly Hospital one DRG ranged from $400 to $59,000. DRG's are also inaccurate to take into account the greater research needs of low income patients who are more likely to have different diagnoses that are severe. The septicemia patient in a charity hospital or any other hospital actually has a 2½ times chance of having tuberculosis as a patient in private hospitals, for example.

DRG's discriminate against patients whose needs can be served without surgery, despite the fact they may need equal or better resource requirements

Substantially, it also discriminates against the public and teaching hospital where there are many more outliers. In NAPH data, 3.5 to 7.1 percent of all public hospital discharges are outliers. I think these numbers are quite conservative. The 1.7 to 3.9 percent is in nonprofit hospitals.

Appropriate safeguards should be built into a DRG base system to account for the tremendous pressures that private hospitals are going to be under to transfer sicker, more complicated cases within particular DRG's.

There will be no incentive whatsoever in this sytem—and I am speaking as a physician and as a hospital administrator—to care for healthier patients on an outpatient basis. The Texas Department of Human Resources criticized Parkland several years ago because we had length of stays for pneumonias of 6.6 days. And the Texas average of 4.2 days. When they came and looked at our system and realized that we didn't admit pneumonias that were single lobe, routine community acquired pneumonias—they were all treated as outpatients because we had no beds—then they paid the 6.6 days because we had saved them an enormous amount of money. And I guess that's the reason we are somewhat concerned about so-called reform. I know how the case mix can be changed favorably. It can be changed by admitting people you would not ordinarily admit, and then making your average more favorable for the institutions.

Many patients will be sicker. I think I agree with the DRG creep that will occur. Very innovative minds working there.

Finally, DRG should take into account the teaching and educational costs, both direct and indirect costs. Defining these will be a problem, and we would like to work with you in every way in this regard.

In short, prospective payment plans based on DRGs fail in many respects to account for uniqueness of the Nation's public teaching hospitals. It seems foolhardy in a way to jump very, very quickly into a system when we haven't had a chance to see what the impact of $12.5 million of medicare cuts you are going to have over the next 3 years will be.

We would like to see it implemented, and implemented when it has been worked out cautiously, quickly. There's no need to phase and phase, but it would be nice to really have a lot of discussion concerning the impact on various types of hospitals that are unique and different.

Public hospitals cannot be rewarded for increased consumption. I think we can take a lead in this regard and be a leader. We have offered this to HCFA.

But I would like to finish this up with basically something that I feel is really a false economy. Cost shift has occurred back to the local taxpayer. That may be where it should be more appropriately put. But here I am in a hospital basically taking care of acute and crisis medicine, high level tertiary care at the same time that we are being, I guess, criticized because of the high cost of medical care. And some of this is quite appropriate. But let me ask you if this is not a little bit schizophrenic when at the same time we are seeing chipping away of support for community health centers, family planning, prenatal care, and nutrition, and preventive health care programs, which I believe to be far more cost effective than anything I can do when I play catcher at the hospital. We need some good utility infielders, I believe, if we are going to have true cost reduction in health care, and not have people suffer needlessly.

I don't believe the cost reduction and crisis care can be compatible concepts in the health care system. So we feel caught in the middle. We didn't create the conditions that produced the acute care need. We have provided it well. We would like not to be the sin bearer for the health care system that really encourages consumption at the present time, or for conflicting Government policies and the general state of the economy. But we are. And as an advocate for the patients we serve, we will be there with our doors open when no one else will be. And we would like to cooperate in every way with this committee, and also with HCFA to develop a system that this country can be proud of. None of us want to see a system where patients do fall through the cracks.

Thank you, sir.

Senator DURENBERGER. Thank you very much.

[The prepared statement of Dr. Anderson follows:]

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STATEMENT OF RON J. ANDERSON, M.D.,
CHIEF EXECUTIVE OFFICER, PARKLAND MEMORIAL HOSPITAL,
DALLAS, TEXAS
BEFORE THE SUBCOMMITTEE ON HEALTH,
SENATE FINANCE COMMITTEE

February 2, 1983

Mr. Chairman, members of the Committee, I am Dr. Ron J. Anderson, chief executive officer of Parkland Memorial Hospital, the public general hospital for Dallas County, Texas and the primary teaching hospital for the University of Texas Southwestern Medical School.

I am also testifying today on behalf of the National Association of Public Hospitals, and I am accompanied this afternoon by Larry S. Gage, President of that organization.

I want to try to do three things in my testimony this afternoon, Mr. Chairman:

- Briefly summarize the overall situation of urban public hospitals in America today -- our institutional safety net -- in the face of Federal, State and local budget crises and increased demand for our services due to the economic recession;
- Illustrate the current problems and concerns which result from that situation through an overview of our current experiences at Parkland; and

Boston City Hospital
Denver General Hospital
Harris County Hospital District (Houston)
College Hospital of the College of Medicine & Dentistry (Newark)
District of Columbia General Hospital
Cleveland Metropolitan General Hospital
Grady Memorial Hospital (Atlanta)
Santa Clara Valley Medical Center (San Jose)
Los Angeles County U.S.C. Medical Center
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
University of Maryland Hospital
San Francisco General Hospital
Contra Costa County Health Services Dept
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
New York City Health and Hospitals Corporation
Glades General Hospital (Belle Glade, Florida)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Cook County Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex

- Provide you with a few comments and observations, against that background, on the Administration's prospective payment proposal.

The Situation of Urban Public Hospitals Today

There appears to be little stomach in American today, Mr. Chairman, for debate of the kind of proposals we used to call "national health insurance". But I would remind you that we can afford that luxury -- of ignoring the huge gaps in our current insurance system -- only because we already have a form of "de facto" national health insurance in most of our urbanized areas today -- in the form of our nation's public hospitals.

We believe this is the single most important fact for you to bear in mind as you consider proposals to reform isolated pieces of the health reimbursement system. Consider the following key facts about our nation's urban public hospitals today:

- PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY. Data being collected for a new American Hospital Association/Urban Institute study shows that just 15 of the largest public hospitals in the country provided $597 million in non-Medicaid charity care in 1980 alone.

- WHOLESALE REDUCTIONS IN MEDICAID ELIGIBILITY, BENEFITS AND PROVIDER PAYMENT LEVELS IN MANY STATES HAVE CAUSED SERIOUS ADDITIONAL STRAIN ON PUBLIC HOSPITALS' RESOURCES. In particular, private hospital dumping of Medicaid and other indigent patients is clearly and measurably on the rise.

- THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS ALSO SUBSTANTIALLY INCREASED. In addition to reductions in Medicaid eligibility, this problem is exacerbated by increased unemployment, and inadequate funding for special populations such as illegal aliens and refugees.

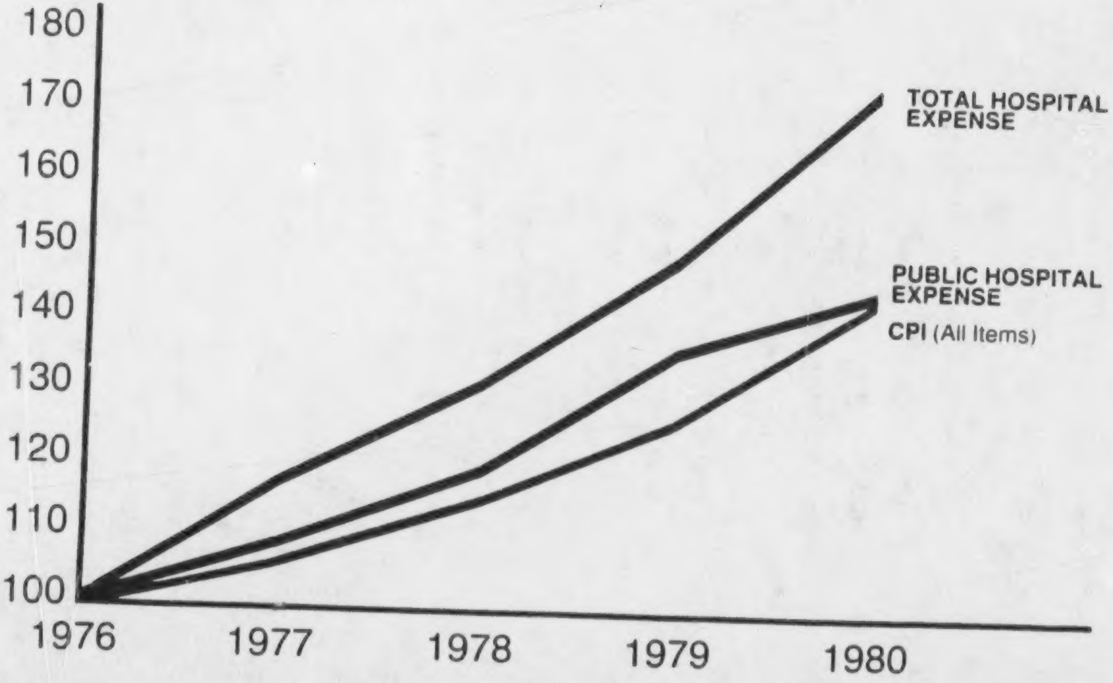
- PUBLIC HOSPITAL BUDGETS HAVE INFLATED FAR LESS RAPIDLY IN RECENT YEARS THAN THE REST OF THE HOSPITAL INDUSTRY. New NAPH data show an average annual inflation rate for public hospital budgets of just 9.8% per year between 1976 and 1980, as opposed to 14.7% for the hospital industry as a whole. (See Chart I.)

- PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES MORE EFFICIENTLY. A recent study by Alan Sager indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of payors in the nation's 52 largest cities. Moreover, only public hospitals have decreased the total number of beds between 1970 and 1980 -- by over 22% -- in those cities.

- PUBLIC HOSPITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS. Just 23 of NAPH member hospitals had 5,254,839 outpatient visits and 2,150,855 emergency room visits in 1980 alone. The total represents nearly 3% of all the OPD visits to all 5830 community hospitals surveyed by the American Hospital Association -- for these 23 hospitals alone!

- THERE IS A GROWING BODY OF DATA WHICH INDICATES POOR PATIENTS ARE SICKER, OFTEN HAVE MULTIPLE DIAGNOSES, AND REQUIRE MORE EXPENSIVE CARE. In addition, such patients also require a range of other unique non-medical services, such as translators, nutrition educators, social workers and specially-trained discharge planners, which adds to the cost of their care.

HOSPITAL INFLATION: PUBLIC HOSPITAL COSTS INCREASED SIGNIFICANTLY SLOWER THAN INDUSTRY DURING 1976-1980



SOURCE:
AHA DATA
AND NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS
SURVEY 1981

- PUBLIC HOSPITALS OFTEN PROVIDE SPECIAL PUBLIC HEALTH AND OTHER UNIQUE SERVICES TO THEIR ENTIRE COMMUNITY, NOT JUST THE POOR. These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few.

- YET MANY OF THESE SPECIAL, COMMUNITY-WIDE SERVICES ARE ALSO IN JEOPARDY, DUE TO SUBSTANTIAL BUDGET REDUCTIONS IN CATEGORICAL HEALTH PROGRAMS AS WELL. From childhood immunization to alcoholism treatment to venereal disease control, actual dollar reductions and block grants have severely hampered the continued ability to perform many of these services.

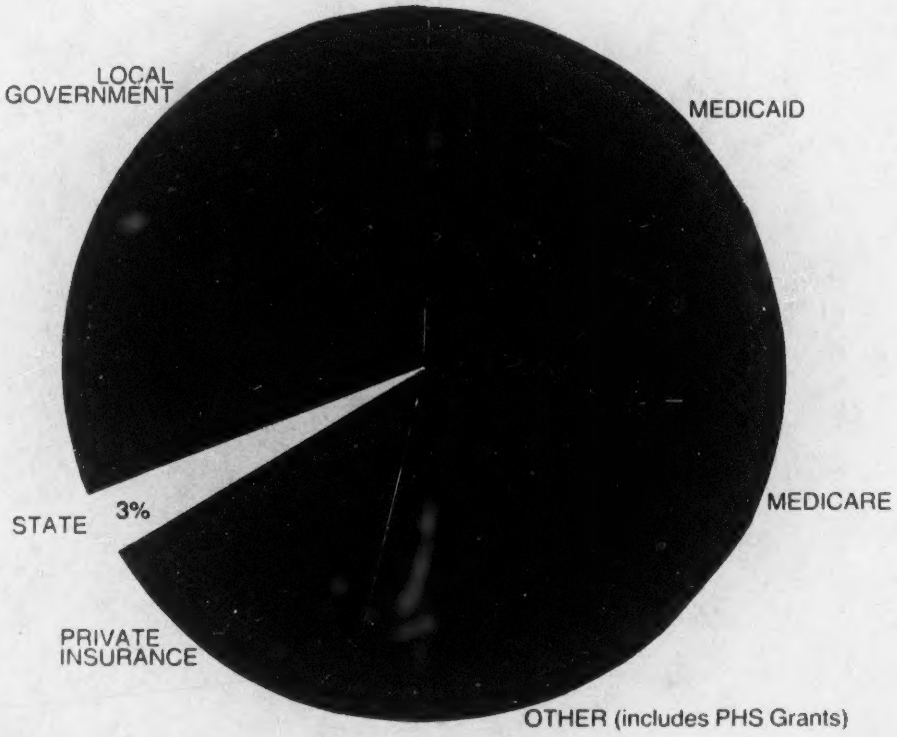
- DESPITE THE PERSISTENT WASHINGTON, D.C. MYTH THAT CITIES AND COUNTIES ARE NOT PAYING THEIR WAY, A SUBSTANTIAL PORTION OF THE PUBLIC HOSPITAL BUDGET COMES FROM STATE AND LOCAL TAX REVENUES. New NAPH data shows 34% of our members' budgets come from State and local appropriations, as opposed to 22% from Medicaid and 16% from Medicare. Of $2.07 billion in total revenues received by just 23 public hospitals in 1980, $709 million were from State and local non-Medicaid appropriations. (See Chart II.)

- PUBLIC HOSPITALS AND OTHER HIGH-VOLUME PROVIDERS OF CARE TO THE POOR HAVE FAR FEWER PRIVATE PATIENTS THAN MOST COMMUNITY HOSPITALS. New NAPH data shows an average of just 12% private paying patients for urban public hospitals across the country. Unlike private hospitals, public hospitals have nowhere to shift costs when governmental funding is cut.

- URBAN PUBLIC HOSPITALS REMAIN THE BACKBONE OF OUR MEDICAL EDUCATION SYSTEM, YET THAT ROLE TOO MAY BE THREATENED BY REDUCED GOVERNMENTAL SUPPORT. New NAPH data shows that just 24 of our member hospitals trained nearly 6,000 of our nation's interns and residents last year. This represents over 10% of all the interns and residents trained in America, for these 24 hospitals alone.

An appendix describing in greater detail the patient population served by public hospitals, the services they provide, their sources of payment, and some of the special needs of their patient population is attached to this testimony.

SOURCE OF REVENUES: NAPH MEMBER HOSPITALS, 1981



SOURCE: National Association of Public Hospitals Survey

The Situation at Parkland Memorial Hospital

As recently as the late 1970s, Parkland suffered from the same problems that afflicted many of the large urban public hospitals in this country. It lacked adequate tax support to keep it on a firm financial footing. The physical plant was beginning to deteriorate; obsolete and worn out equipment was not being replaced in a timely manner. Employee moral was poor and turnover was high. The hospital projected a negative image to the public and frequently became a political football in local political arenas and the news media.

In late 1978, however, business leaders, political leaders, and other influential citizens of Dallas moved to bring a halt to Parkland's downhill slide. A new, stronger hospital board was appointed by the County Commissioners. New, aggressive management was brought in starting in mid-1979 and immediately addressed serious problems in both the delivery of patient care and financial management.

In January 1980, the hospital board and administration mounted a short but intensive campaign and won overwhelming voter approval for an $80 million bond issue to upgrade and expand the hospital. That project is currently underway and the new construction is expected to be completed in mid-1985.

Local tax support also improved dramatically and the hospital district actually ended fiscal 1981 with an excess of revenues over expenses. The hospital district's financial strength was demonstrated further by the high ratings given to the construction bonds -- AA+ by Standard & Poor's and Aa-1 by Moody's, the highest ratings granted to public hospitals. Parkland has now gone three years without requesting a tax rate increase for hospital operations.

Concurrently, Parkland has shed its negative public image and is increasingly seen as a major community asset and resource, rather than as a social burden. The County Commissioners tell us happily that they no longer have to run for cover when constituents mention Parkland.

But Mr. Chairman, members of the Committee, I am here to tell you that local support has its limits and Parkland, like the other large urban hospitals, is being buffeted about by conditions and forces beyond its control. It is caught in a vise of increasing demand for its services on one side and shrinking resources on the other. It is a vise caused in part by the economic recession and in part by contradictory and self-defeating government policies.

As the recession and accompanying unemployment problem have dragged on, there are a growing number of people in Dallas County who have lost their health insurance. These people now turn to Parkland for their medical care, knowing they will not be turned away for financial reasons. Thus, while private hospitals see their occupancy rates fall during the recession, Parkland is busier than ever.

Emergency room visits have jumped dramatically during the recession and now average between 500 and 550 per day. The rate of patient transfers from other hospitals to Parkland has nearly tripled over the past year and is now occurring at the rate of almost 200 per month. Most of these transfers are for financial reasons and frequently involve medically indigent residents of neighboring counties and suspected illegal aliens. We estimate the amount of care rendered to these patients costs Dallas County taxpayers roughly $6 million a year.

Outpatient clinic visits also have increased markedly and range between 800 and 900 per day. Recently, we have begun charging an up-front $5-fee to all clinic patients, except for Medicaid and Medicare patients. This has been necessary to help offset reduced reimbursement from Medicare and Medicaid. Previously, charity patients did not have to pay in order to be seen in the Parkland Outpatient Clinic.

The combined effects of the recession and the cutbacks in federal funding for family planning and community health centers is being acutely felt in the obstetrical units and newborn nurseries at Parkland. Newborn deliveries are now occurring at the rate of about 1,000 per month and are running 14 percent ahead of the same quarter last fiscal year. The occupancy rate for the normal newborn nursery remains constant at more than 100 percent, and the neonatal intensive care unit is frequently more than 100 percent occupied in terms of licensed capacity.

To cope with the increase, we have had to hire more nurses and find ways to stretch our resources, such as employing medical students, under the direction of faculty, to handle uncomplicated deliveries. We also have tried -- with only moderate success -- to make arrangements with private hospitals to take some of the high-risk pregnant women and their acutely ill newborns when our units are full. We are trying to explain to the other hospitals with Level III nurseries that we are willing to reimburse them for Dallas County indigent patients who they accept, but that they, especially the tax-exempt, non-profit institutions should take care of non-county indigent patients who are sent to them for care. We feel this is an obligation that goes along with operating a Level III nursery.

In financial terms, all this has yielded red ink for the hospital district. Our recently completed annual audit shows that Parkland went from a net income from operations of more than $6 million in fiscal 1981 to a loss from operations of more than $1.6 million in fiscal 1982. Only the hospital district's non-operating income in 1982 enabled the hospital district to end the year with a positive excess of revenues over expenses. This fiscal year, we have seen tax receipts lag as taxpayers hold onto their money for as long as they legally can do so, and this will cost the hospital district several hundred thousand dollars in lost interest income.

In order to keep the hospital on firm financial footing, it may be necessary to ask the County Commissioners to increase the hospital district tax rate for fiscal 1984. This is simply shifting the cost of providing necessary health care from the Federal level to the local level. Yet Dallas County taxpayers already provide 57 percent of Parkland's operating revenue, compared to the national average of 34 percent for the nation's major public hospitals. Thus, while there is much talk about shifting responsibility for health care from the Federal government to the local level, the urban counties in Texas have already assumed that responsibility. One can only wonder how much more responsibility local taxpayers will be willing to bear.

Furthermore, expenditures for Parkland could not be cut without reducing services or the quality of services. Parkland is already rated among the top three institutions in a productivity study conducted by the Texas Hospital Association. The hospital also has been aggressive in the area of cost containment. Although the cost of health care continues to rise nationally, the rate of increase among public hospitals, such as Parkland, is smaller than the rate for the hospital industry as a whole. Furthermore, the rate of increase -- adjusted for increases in the volume of service -- at Parkland specifically has declined steadily in recent years.

If this scenario of increased demand for basic services and reduced reimbursement continues, we will also see another unfortunate consequence for Dallas County residents and for the nation's health care system. The public teaching hospitals, of which Parkland is one, will become so overburdened by the demand for acute or crisis care that their ability to develop innovative treatment methods and preventive health care will be hamstrung. Already, it is not uncommon for Parkland and other public hospitals to maintain long waiting lists of patients seeking elective procedures or diagnostic work-ups because empty beds are unavailable.

Medical school faculty physicians in some cases also are caught in the middle. New proposed Medicare reimbursement policies will sharply restrict payment of fees for hospital-based physicians, such as radiologists and pathologists. Now the medical schools are turning to the public hospitals, i.e., local taxpayers, and asking them to pick up the cost. Cost-shifting strikes again.

Finally, Parkland has become saddled with new Medicare reimbursement limits under TEFRA that will penalize us for our prior efficiencies -- while refusing to acknowledge despite a clear Congressional mandate that we should receive an adjustment to those limits to recognize the uniqueness of our public mission and the patient population we serve. NAPH is now engaged in an extensive debate with HCFA over their failure to provide such an adjustment -- a debate we may need to ask

Congress to resolve through a clarification of your clear recognition of the important role played by our "safety net" institutions.

The Administration's Prospective Payment Proposal: Public Hospital Concerns

At the outset, let me state that NAPH joins with the American Hospital Association and others in fully supporting the current trend toward a comprehensive, equitable prospective payment system for hospitals and away from the confusing assortment of cost and charge-based payment mechanisms which have characterized our reimbursement system to date. We are concerned, however, that there have developed over the past year a great many "prospective payment" proposals for reform at the Federal and State level. We believe the various elements of these proposals need to be carefully evaluated before a new system is legislated, along with the as-yet-unknown impact on our nation's hospital system of the many recent changes in Medicare and Medicaid reimbursement laws and policies.

For this reason, independent of our substantive concerns about the Administration's proposal, we strongly urge this Committee to reject any effort to adopt it -- or any other major system reform -- as part of any "fast track" legislation such as the Social Security Act amendments.

In the balance of my testimony, I would like to turn briefly to the specifics of the Administration's current DRG-based proposal. We will undoubtedly have additional comments when draft legislation has actually been prepared and made available. However, we would like to make several general observations about what we believe are some of the proposal's current deficiencies:

1. The proposal applies only to Medicare inpatient services.

While we recognize the current political impracticality of any prospective payment proposal which would apply to all payors, we question the wisdom of Congress adopting a new system at this time which does not. Nor can there be genuine reform, in our opinion, unless the services and resource needs on the outpatient side are also taken into account.

2. The proposal makes no provision for hospitals serving significant numbers of low income patients.

Cost shifting is a very real phenomenon today, and under our current reimbursement system, a necessary one -- particularly as long as all payors continue to receive one form or another of taxpayor subsidy. As pressure increases among payors to end or reduce cost shifting, however, the patients whose costs must be shifted will become increasingly isolated. When no organized insurer admits to any responsibility for serving the uninsured poor, those patients will increasingly be dumped on our nation's public hospital system -- at least up to the limits of local taxpayers' willingness to support that tremendous burden. After those limits are reached, they will simply be dumped period. While the common wisdom is that Medicare should assume no responsibility whatsoever for non-Medicare patients, we believe that wisdom must be challenged when it comes to our "safety net" providers. In those institutions, at least, services provided to uninsured patients must be factored into any major prospective payment reform.

3. NAPH has serious concerns about the DRG system upon which the Administration's proposal is based.

Our significant concerns about the DRG system include the following:

- DRGs appear to be inadequate to take into account the tremendous variation in resources which can be required by patients with the same principal diagnosis. Dr. Susan Horn, of the Johns Hopkins University, has pointed to one DRG, for example, in which the charges varied within a single hospital from $400 to $59,000. We believe that low income patients are far more likely to require additional resources than middle class patients with the same diagnosis.

- DRGs are also inadequate to take into account the greater resource needs of low income patients who are more likely to have several different diagnoses. Public hospital septicemia patients, for example, are 2-1/2 times more likely to have tuberculosis than those in private hospitals. Moreover, many of the disease categories more prevalant among public hospital patients -- mental illness, trauma, infection, diabetes -- are those in which patients are more likely to require a wider range of resources.

- DRGs discriminate against patients whose needs can be served without surgery despite the fact that such patients in public hospitals may have equal or greater resource requirements. Public hospitals perform far fewer elective surgeries than their private counterparts, for example, and our patients are far more likely to be admitted through the emergency room. At Parkland, 75 to 80 percent of our patients are admitted through the emergency room, compared to 20 percent at a large private hospital. We also currently operate eight intensive care units, including a small pediatric trauma intensive care unit.

- By expressing the goal of narrowly defining the number of "outlier" cases for which reimbursement will be available outside the system, the proposal will substantially discriminate against public and teaching hospitals. 3.5 to 7.1 percent of all public hospital discharges are "outliers", with longer than average length of stay, as compared with 1.7 to 3.9 percent in non-public hospitals.

- Unless appropriate safeguards are built in to a DRG-based system, there will be tremendous pressure on private hospitals to transfer their sicker, more complicated cases within a particular DRG to the hospitals who cannot refuse them.

- Even if such DRG-induced dumping does not occur, there will be no incentive whatsoever in such a system to care for healthier patients in less costly outpatient settings. Indeed, healthier patients within particular DRGs will become prizes to be wooed and won by hospitals with the luxury to compete for them. Thus, with a single stroke, this so-called "reform" will end any prospect of substantial future savings from current positive trends away from unnecessary hospitalization. A few years ago, the Texas Department of Human Resources sharply questioned why the average length of stay for pneumonia patients at Parkland was 6.6 days instead of the state average of 4.2 days. The answer was that because of the shortage of beds in the hospital, only the most severe cases of pneumonia were admitted to the hospital; the other cases, which would typically be admitted to a private hospital, were treated on an outpatient basis.

- In addition, many patients themselves will get "sicker" under a DRG system -- at least on paper. "DRG creep" and other exotic phenomena will become the order of the day, as hospitals seek to maximize reimbursement-by-diagnosis under the new system. Anecdotally, at least, this phenomenon appears already to be occurring in New Jersey -- along with other less pleasant stories about hospitals discharging patients before they are well, in order to be able to admit them again under a different diagnosis. If these stories prove to be fact, the system will have created some perverse incentives indeed.

- Finally, DRGs also fail to take into account the teaching and educational costs which are incurred by primary teaching hospitals, such as Parkland. While the proposal expresses the goal of "passing through" certain teaching costs, the adequacy of that pass through will have to be carefully examined.

In short, the prospective payment plan based on DRGs fails in many respects to take into account the uniqueness of the nation's public teaching hospitals. Furthermore, it hardly seems reasonable to jump into a radical new financing scheme when we are all still evaluating the impact of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which will reduce Medicare reimbursement by $12.5 billion over the next three years.

I must point out that unlike most private hospitals, public hospitals are not rewarded for increased consumption. We operate on a predetermined budget, much like a health maintenance organization. Unlike an HMO, however, we cannot open and close our enrollment period as economics dictate. Our doors are always open.

While the DRG formula poses a specific problem for public hospitals, it is not as disturbing and as frustrating to me as the overall tendency among governmental decisionmakers toward false economies and contradictory policies in the area of health care. On the one hand, Administration after Administration in Washington preaches the need to rein in health care costs, a goal which public hospitals whole-heartedly endorse. On the other hand, the Administration and Congress persist in chipping away at the community health centers, family planning, prenatal care, nutrition, and other preventive programs, which in many instances are far more cost-effective than hospitalization programs. Instead of supporting preventive care and early intervention, the government continues to promote crisis care, which is the most costly, both in human and financial terms. The government is zeroing in on the providers of medical care, while all but encouraging growth in the legitimate demand for health care. Cost reduction and crisis care are simply incompatible concepts in our health care system.

The large public hospitals are caught in the middle. We don't create the conditions that produce the acute need for medical care. We should not be made the sin-bearers for the health care system, government policies, and the general state of the economy.

I appreciate the opportunity to testify here today, and now I would be happy to respond to any questions or comments you may have.

Senator **Durenberger**. My first observation is that you said more in 12 minutes than most of us have been able to say in twice as much time today. It is not derogatory of anybody else, but you must have taken a speed speaking course, and you did very well. Let me see if I can summarize your major points. You see the health care system in this country in a unique way because you are the bottom of the safety net, and you are the place where everybody goes. When the flaws appear in the rest of the system, you end up seeing the uncovered and the uncared for.

You shared the frustration you have to deal with in terms of cost shifting, cost cutting, and all of the other effects of what we have been doing the last 2 years.

But the fact that this process will probably work this year about as fast as you have just delivered that message, rather than the way you have cautioned us to go in a slow deliberate means, is because a lot of us are bothered by the idiocies of budget cutting, cost shifting, and are rather anxious to try to change the system.

I thought I read into your statement a preference for a prospective system over a cost-based system. I also thought I read into your statement—and you were weaving between Parkland and your 40-member association—so I wasn't sure where I got the 16 percent of your patient-days were medicare.

Dr. **Anderson**. That's NAPH data. Parkland is only 13 percent.

Senator **Durenberger**. OK. With that relatively low level of medicare, I was wondering a little bit about why you are so concerned. Perhaps it's a concern that if we bring to medicare an unrealistic DRG system and then all of a sudden everybody starts adopting that system, a greater proportion of your revenues will be affected. Could you comment on that?

Dr. **Anderson**. I think my concern, Senator, is that we have no place to put the patients if the patients become less attractive to other institutions. Right now, they have a very soft census in our community. Their hospitals are emptying because of the economy. People aren't getting elective surgery. Their office practices for the physicians are decreasing while we are having a booming business. In fact, medicare pays us more than the 67 percent total charity care that we receive. But we are taking care of those who already have fallen through the eligibility cracks to us.

We don't have a place to put the medicare patient. I would be very pleased to have medicare payment, but I have no place to put the patient. And our mandate is to take care of the very poor there. And we've seen them being possibly displaced. But we have no place to put them. So I don't know where the patients would go if they left the system.

If the nonprofit system, though, is empty, and they are overbedded, I think they will take the patients gladly. I think you'll be able to be quite competitive and be able to talk with them very sincerely as long as their beds are empty. But with the economy improving, then I think they would come back into the system; they could utilize the system on the old way—the more you consume, the more you make.

And I think that that would only take us to bankruptcy. So prospective reimbursement seems to be a wise move if we can do it in a way that would recognize the unique variables. Teaching hospitals are different. And the public hospitals, with their segment of the population that they serve, are also different. I think they are sicker.

Politically, we have made a decision at Parkland and many of the public hospitals—because we are next door to medical schools many times, to develop services that no one else in the community would initiate. Many of these programs now are in jeopardy because the mandated services will push those patients out.

I could increase local taxes on our Dallas homeowner by about 10 to 12 percent if the paying patients in my institution are pushed out by the mandated services. And that's where we would go. And I could easily go back and say you need to give me 12 percent more to run the hospital if I am not to ration care.

So I guess my concern is not because we have so many medicare patients but because many of the hospitals in my community do. And anything that jeopardizes those nonprofit volunteer hospitals that have cooperated with us will have an impact on us in a very short order. We've tripled the number of referrals from other hospitals on a financial basis in the last year. So many of the patients who are not attractive now in DRG classification or any classification are coming to Parkland. And there will be a point when we are running 95 percent, 97 percent census today that I won't have a place to put them.

Senator **Durenberger**. What does the case mix look like today as opposed to 3 or 4 or 5 years ago?

Dr. **Anderson**. The case mix at Parkland has always been very intense. It's been a very good training program. But I think also many of the patients referred to us aren't any necessarily sicker. Some are. If we look at DRG's transferred, many of those patients are going to be patients who are very high cost patients.

Susan Horn at Baltimore showed that 14 percent of the pediatric cases in a hospital there consumed 50 percent of the health care dollars. And if I want to have a good hospital that makes money on the prospective system, I will develop my market basket, my product, to leave out those sorts of things. I won't take care of some of those things because the hospital down the street can take care of those.

I heard Secretary Schweiker say that the hospital down the street may be better prepared to handle some of these things, and there's no question that is true. We are. But if the other hospitals cut off parts of their package for total comprehensive care, they are not attracted to them from a financial point of view. Someone will have to pick it up or it will have to go undone. And we would like to be reimbursed for having that extra expertise.

We have 35 doctors on in the emergency room at any one time as a trauma hospital. And we admit as many people from 11 to 7 as we do from 7 to 3 on the shift. We have a 24-hour, 7-day-a-week operation. We have to pay for that when people come in. And we think we do pay for it. But I'm not sure that the other people would want to bear that expense.

Senator DURENBERGER. Is there any kind of a community health planning system in place in Dallas?

Dr. ANDERSON. Yes.

Senator DURENBERGER. Can you describe it to us briefly?

Dr. ANDERSON. There are several tiers in the planning system. There was a health systems agency and a subcommittee there. That's all been now taken to Austin. The area subcouncils have been dissolved, and there will only be one in Austin. There has been a CON process, of course. There is an area council. The large hospitals that have teaching programs that work together and try to cooperate. And we have city planners and city fathers involved in many of the programs, and the development programs in the community. Not only to look at tertiary care in the public hospitals but the community clinics as well. And, as you know, they've been under quite an assault. And we've closed a number of them in the community. So that's a lot of the increase in load we have at Parkland now because of the closure of some of the clinics.

Senator DURENBERGER. Have any hospitals in Dallas closed?

Dr. ANDERSON. No. There have been certain of the clinics closed. They have been lending care primarily to the same patients we take care of now.

Senator DURENBERGER. I see. But the certificate of need process is being operated at a State level?

Dr. ANDERSON. At the State level, yes, sir. There was an area subcouncil that handled it initially—the health systems agency—that was dissolved within 2 weeks ago, and it is now handled at the State level through the health facilities commission.

We are not overbedded in Dallas in the public sector. The private sector probably is in our view.

Senator DURENBERGER. But the community's response to some of these problems in terms of where health care is going to be provided in a hospital setting is fairly informal?

Dr. ANDERSON. The community's answer is that it will be taken care of at Parkland.

Senator DURENBERGER. All right.

Dr. ANDERSON. And that's basically traditional also. We have always handled that. Some of the nonprofit volunteer hospitals have taken care of a certain amount of charity and bad debt obligation also, but it's a very small component compared to what has been provided at Parkland.

Actually, I might give you one piece of information about Texas. We looked at four hospitals recently in an article in the Texas Medical Association's journal, and four hospitals—Parkland, Bentab in Houston, Bear County in San Antonio, and Galveston, the State hospital—delivered $315 million worth of uncompensated nonmedicaid care in 1981. And the State medicaid program in Texas for all hospital pay and physician pay in hospitals, including outpatient clinics and emergency rooms, was only $250 million. So we've had New Federalism, if you want to call it that, in Texas for a long time. And we feel like we are going to be cutting a lot of lean along with the fat.

Senator **Durenberger**. Well, speaking of New Federalism, we may want you to come back later in the year when we talk about the "potential for federalizing medicaid" as it relates to the bottom of the safety net. Folks don't know what it is we talk about when we talk about sensible delivery of health care for the needy in America. And if you are willing to do that, we would be glad to reextend the invitation.

Thank you very much for being here today.

Our next and final witness is Mr. Richard Fluke, the executive director of the Tennock Hospital in Hastings, Mich., and chairman-elect of the Michigan Hospital Association, on behalf of the Michigan Hospital Association.

We welcome you to the hearing. Your prepared statement will be made part of the record. You may abbreviate it or anything else you care to do within approximately a 10-minute time limitation.

STATEMENT OF MR. RICHARD FLUKE, EXECUTIVE DIRECTOR, PENNOCK HOSPITAL, HASTINGS, MICH., AND CHAIRMAN-ELECT, MICHIGAN HOSPITAL ASSOCIATION, ON BEHALF OF MICHIGAN HOSPITAL ASSOCIATION, LANSING, MICH.

Mr. **Fluke**. Thank you, Mr. Chairman. I am Richard Fluke, chairman-elect of the 210-member Michigan Hospital Association and the executive director of Pennock Hospital in Hastings, Mich.

Joining me today is Steve Scheer, director of health economics for the Michigan Hospital Association.

I am pleased to appear before you to present the views of the Michigan hospitals on the Department's prospective payment system proposal.

At the outset let me say that Michigan hospitals are impressed with the quality of work that has gone into the proposal. Secretary Schweiker and Dr. Carolyne Davis, the Administrator of Health Care Financing Administration, are to be complimented for their and their staff's efforts.

The observations on the proposal that I want to share with you today are based in significant part on Michigan's experience with one form of prospective payment methodology, a methodology which has been in use in our State since 1978 and which affects about $2 billion in payment to hospitals. I just might add that that experience is with the Blue Cross/Blue Shield organization. A payment developed between the hospitals and Blue Cross/Blue Shield.

In addition, my observations will address the implications of the proposal for our recession-ravaged economy, the effects of which in Michigan include a 17-percent unemployment rate, a cash-starved medicaid program, and a very large volume of uncompensated hospital care, which resulted in a shortfall in hospital revenues that in 1982 saw a staggering 29-percent increase to $142 million. I would like to emphasize that this was uncompensated care; not necessarily contractual adjustments. And although that is not as much as we just heard from Texas, to put this in a perspective that perhaps we can relate to, the $142 million of uncompensated care for poor patients in Michigan is more than the combined medicaid budget of 26 States.

Our thoughts on the proposal include: First, the promise of prospective payment derives from the market incentives it offers to hospitals to lower their costs. For this incentive to be meaningful, it should be consonant with the capacity of hospitals to make the intended changes. Otherwise, the system would become not an instrument for reform of hospital practices, but a measure to push into bankruptcy hospitals that are already walking along a fiscal tight rope.

To develop a method that quickly and sharply changes payment levels, but does not allow opportunity for management to adapt to the method, will lead only to random losses and unsatisfactory performance. It is unclear that the DRG based proposal reflects the degree to which management may control their hospitals 'results. For example, hospital managers have high degree of control over employment and salaries, and, therefore, can be held largely accountable.

Less influence is exerted over the treatment regiment and health inputs for individual patients. And this influence must be applied by management and hospital boards working with medical staff. This influence can be exerted only gradually over a period of time. As a result, systems which apply financial accountability to hospital management should take account of the degree to which management can make the system effective in any given period of time.

It seems to me that this question of capacity for control—its amount and its timing—should be a major element in your evaluation of what type of payment proposal should be developed.

Second, the proposal is devoid of a major characteristic which in our State has meant the difference between success and failure for our prospective system. That characteristic is that payment is predicted on the individual circumstances of hospitals. Two modifications could be introduced into the proposal which would assist in this regard.

The first would require that the initial payment policy be established in the individual cost structure of each hospital with movement to peer groupings in the future. The ease with which a hospital can adapt to a new system depends on the initial distance between a hospital's circumstances and the system's financial goals. The system should take this factor into account.

The second modification is the need for a fair appeals system to reflect relevant factors not accounted for in the basic plan. We believe a community based appeals system would best be able to take account of special local factors.

In my opinion, both modifications form a safety net under the experiment, a safety net which could mean the difference between a successful transition to a new system, or a harmful and chaotic disruption in the delivery of health care.

Our third observation involves the opportunity for alternative experimentation at the State level. If hospitals and the State agree, there should be an opportunity for the Federal Government to participate in different payment methodologies. The key here, however, is to assure that these normally opposing parties are in agreement before any alternative is accepted.

Finally, the proposal should be strengthened technically as it relates to the basis of the initial determination of payment per case. The factors which go into this payment should reflect a fair based price, and that includes establishment of appropriate elements of cost; particularly, factors for future capital replacement and uncompensated care, and reflect the legitimate increases in cost over time that flow not only from price changes, but improvements in services for the general population. Failure to recognize the latter would drive the system to provide a lesser level of care for medicare beneficiaries than for others.

Mr. Chairman, this concludes my observations. If there are any questions, we would be pleased to attempt to answer them.

Senator DURENBERGER. Thank you.

[The prepared statement of Mr. Fluke follows:]

TESTIMONY OF
RICHARD M. FLUKE
CHAIRMAN-ELECT
OF THE
MICHIGAN HOSPITAL ASSOCIATION

Mr. Chairman and Members of the Committee, I am Richard Fluke, Chairman-elect of the 210-Member Michigan Hospital Association and the Executive Director of Pennock Hospital in Hastings, Michigan. Joining me today is Steven Scheer, Director of Health Economics for the Association. I am pleased to appear before you to present the views of Michigan Hospitals on the Department's prospective payment system proposal.

At the outset let me say that Michigan Hospitals are impressed with the quality of work that has gone into the proposal. Secretary Schweiker and Dr. Carolyne Davis, the Administrator of Health Care Financing Administration are to be complimented for their and their staff's efforts.

The observations on the proposal that I would like to share with you today are based in significant part on Michigan's experience with one form of prospective payment methodology -- a methodology which has been in use in our state since 1978 and which affects about two billion dollars in payment to hospitals. In addition my observations will address the implications of the proposal for our recession-ravaged economy, the effects of which in Michigan include a 17% unemployment rate, a cash starved Medicaid Program, a very large volume of uncompensated hospital care which resulted in a shortfall in hospital revenues that in 1982 saw a staggering 29% increase to $142 million.

My thoughts on the proposal include:

1) First the promise of prospective payment derives from the market incentives it offers to hospitals to lower their costs. For this incentive to be meaningful it should be consonant with the capacity of hospitals to make the intended changes. Otherwise, the system would become not an instrument for reform of hospital practices but a measure to push into bankruptcy hospitals that are already walking along a fiscal tight rope. To develop a method that quickly and sharply changes payment levels but does not allow opportunity for management to adapt to the method will lead only to random losses and unsatisfactory performance. It is unclear that the DRG based proposal reflects the degree to which management may control their hospitals' results. For example, hospital managers have a high degree of control over employment and salaries and therefore can be held largely accountable for both, not necessarily instantaneously, but at least over a period of time, taking into account labor-management contracts and negotiations. Less influence is exerted over the treatment regimen and health inputs for individual patients, and this influence must be applied by management and hospital boards working with medical staff. This influence can be exerted only gradually over a period of time. As a result systems which apply pecuniary accountability to hospital management should take account of the degree to which management can make the system effective in any given time period.

I may be wrong but it seems to me that this question of capacity for control -- its amount and its timing -- should be a major element in your evaluation of what type of payment proposal should be developed.

2) Secondly, the proposal is devoid of a major characteristic which in our state has meant the difference between success and failure for our prospective payment system. That characteristic is that payment is predicted on the individual circumstances of hospitals. Two modifications could be introduced into the proposal which would assist in this regard:

The first modification would require that the initial payment policy be established in the individual cost structure of each hospital with movement to peer groupings in the future. The ease with which a hospital can adapt to a new system depends on the initial distance between the hospitals circumstances and the system's financial goals. The system should take this factor into account.

The second modification is the need for a fair appeals system to reflect relevant factors not accounted for in the basic plan. We believe a community-based appeals system would best be able to take account of special local factors.

In my opinion both modifications form a "safety net" under the experiment -- a safety net which could mean the difference between a successful transition to a new system and a harmful and chaotic disruption in the delivery of health care.

3) The third observation involves the opportunity for alternative experimentation at the state level. If hospitals and the state agree, there should be an opportunity for the federal government to participate in different payment methodologies. The key here however is to assure that these normally opposing parties are in agreement before any alternative is accepted.

4) Finally, the proposal should be strengthened technically as it relates to the basis of the initial determination of payment per case. The factors which go into this payment should reflect a fair base price and that includes establishment of appropriate elements of costs particularly factors for future capital replacement and uncompensated care and reflect the legitimate increases in cost over time that flow not only from price changes but improvements in services for the general population. Failure to recognize the latter would drive the system to provide a lesser level of care for Medicare beneficiaries than for others.

This concludes my observations. If there are any questions, I would be more than pleased to attempt to answer them.

Thank you for your kind attention.

Senator DURENBERGER. I will try to minimize the questions because your testimony is very forthright, and it represents the reaction of a very responsible association of health care systems in a recession-ridden State trying to survive long enough to provide some adequate level of care for the people of Michigan. From that perspective, your appearance here is valuable because we tend to see things around here on the basis of averages. And yet that isn't the way the Nation is put together.

One of the questions I would like to ask you concerns unemployment. A lot of people in Michigan today are unemployed, persons who because of the nature of their previous employment had fairly good health care coverage from employer based health plans. You may be able to tell me with regard to the automobile industry the current costs of some of those plans. But I distinctly recall 3 years ago when the president of the United Auto Workers was trying to persuade me to support the Chrysler bailout, and I asked him how much their Blue Cross plan cost Chrysler, and he said $243 a month. And that was at a time when the average family coverage was costing nationwide something like $105 or $110. I don't know what that cost may be today. I presume the Chrysler coverage is still fully paid. But I feel that if a more realistic relationship was developed in health care between employers and employees in this country, we might be in a better position to persuade employers to carry people through some period of unemployment.

We have a proposal the administration has endorsed this year that might go part way in moving the Nation toward some kind of a sensible relationship in the employer-employee health benefits plan. It is commonly called a tax cap. You have propably heard about it. In effect, the administration's proposal is that $175 a month worth of family coverage, and some lesser amount for single coverage, is the kind of relationship that we ought to encourage. Anything above that is taxable income, and tax revenues might be used to care for those charity cases we just heard about; might go into paying unemployment compensation; might go into buying a roof to put over the heads of homeless rather than being squandered in excess health benefits.

So having said all that, I would appreciate your comments on the current situation as you see it in Michigan, and how you feel about that administration proposal.

Mr. FLUKE. Let me speak as a hospital administrator now and not entirely for the Michigan Hospital Association.

Senator DURENBERGER. Yes.

Mr. FLUKE. As a hospital administrator, we are very concerned about people that come to our door with all inclusive benefits. And the problems you have on overuse of those. And any change in the system to put a little bit of responsibility on the patient to look for less cost or less activity, unnecessary use of the system, we would support. I think when you talk about the Chrysler situation or the Michigan situation, you are talking about workers who had negotiated top level benefits, leaders in the country in benefits. A history of their organization that was dedicated to those types of benefits for their workers.

Unfortunately, a couple of things happen. You get over or excess utilization. And another thing, there are people out there that will provide services to get on that bandwagon and start up storefront clinics and so on to reap the benefit of the all-inclusive services that the workers have.

I know when I served a few years ago on the Blue Cross Board, they had a big problem with psychiatric benefits that the workers had received, and within 2 years had spent 10 times, many times, the amount of money on that one benefit because all of us can stop once in a while and talk to our friendly psychiatrist and feel better. And there was no limit on the amount of utilization. Most of us won't have $250 a month coverage for employees. But some organizations and employers have gotten into that situation.

We would support something along the administration's line of somehow controlling overutilization through the patient participating in a small cost.

Senator **Durenberger**. Can you see in the State of Michigan among employers a new awareness of the whole issue that we are discussing here in terms of the high cost of health care and providing options and alternatives?

Mr. **Fluke**. We've had an experience like that just in Hastings, which is a small town outside of Grand Rapids, about 30 miles away. Just recently, in the last month, two of the major employers in town have asked their workers to take concessions. Those concessions included the worker now paying a small coinsurance or a small deductible on programs that were fully paid for by the employer. And in order to retain their jobs, and in order to keep jobs in the community, the workers agreed to that. Now that's not always the case, but you are seeing more of that activity just in the last year than you have ever seen before.

Senator **Durenberger**. Well, thank you very much for taking the time to come. And thank you, in particular, for your insight into the issue that is before us today, and for your willingness as an individual administrator to answer the other question, which will be very important to the members of this committee as time goes on.

Mr. **Fluke**. Thank you, Mr. Chairman.

Senator **Durenberger**. The hearing is adjourned.

[The prepared statement of Mr. Louis P. Scibetta (not present at hearings) follows:]

TESTIMONY OF
LOUIS P. SCIBETTA, PRESIDENT
NEW JERSEY HOSPITAL ASSOCIATION

Mr. Chairman and members of the Committee, I am Louis P. Scibetta, President of the New Jersey Hospital Association. The Association, which represents all the hospitals in New Jersey, wishes to express its appreciation for the opportunity to appear today and present testimony on the Department of Health and Human Services plan for Medicare prospective payment to hospitals.

As you know, New Jersey hospitals are entering the fourth year of a four-year "waiver" granted by the federal government where medicare and medicaid have waived their principles of reimbursement and have agreed to pay hospitals pursuant to a state-approved prospective DRG rate schedule. As a consequence, no other state in the nation has had the experience that New Jersey has had with DRG hospital reimbursement.

It is my intent today, Mr. Chairman, to pass along to you and the other members of the Committee our views of the proposal based on the experience our hospitals have had with such a system.

The prospective plan submitted by the Department of Health and Human Services proposes to pay DRG payment rates for inpatient hospital care received by Medicare patients. The Department has indicated that it can implement the plan on October 1, 1983.

The following remarks address methodological and procedural aspects of the proposed plan. The methodological comments focus on how prospective prices are to be calculated. The procedural remarks relate to details that must be considered in designing a prospective plan.

I would like to preface my remarks by emphasizing that in reviewing the New Jersey experience, it is crucially important to distinguish between Diagnosis Related Groups (DRGs) and Chapter 83 of the Laws of 1978, our state law on hospital reimbursement. DRGs are a patient classification scheme. Chapter 83 set the ground rules for hospital rate calculation. In New Jersey, Chapter 83 guarantees the solvency of effectively and efficiently operated hospitals.

Prospectivity

The payment rates are to be established prospectively, based on historical costs, and are to remain unchanged during the rate year. Hospitals are to be allowed to retain or absorb the entire difference between the payment rates and actual cost.

We applaud the notion of prospectivity and welcome the intention to build reasonable incentives into the proposed program. Prospective rates augment the ability of hospitals to plan and budget, primarily because revenues for the upcoming year can be projected more accurately than otherwise. Meaningful opportunities to earn discernible incentives will motivate hospitals to function as efficiently as possible. Rarely are incentives found in fully cost-based reimbursement schemes

Our experience with prospectivity in New Jersey has taught us, however, that prospective systems are significantly cleaner in theory than in practice. One major difficulty is the timeliness with which the rates are issued. Last year, for example, 20 to 25 New Jersey hospitals had not received their 1982 prospective rates by late September. Yet those hospitals' income for the year was pegged to those rates. Another problem relates to the fixed nature of the rate. The Medicare proposal wants the rate to remain unchanged during the year, a goal that is extremely problematic in practice. For example, an absolutely fixed rate precludes adjustments for serious misprojections made in arriving at future rates and corrections of subsequently uncovered errors. To keep rates fixed under these circumstances is simply inequitable.

In this vein, we are extremely concerned with the Department's proposal to implement a plan that is not subject to judicial review.

> "Payment amounts, exceptions, adjustments, and rules to implement the prospective payment system would not be subject to any form of judicial review. Retroactive adjustment of the payment rates, as might result from judicial review, is unusual to the basic purpose of prospective system." (p.41)

Hospitals should not be denied judicial review if they wish to contest aspects of their approved rates. If the plan is as sound as claimed and is implemented fairly with sufficient lead time, few hospitals will need to resort to judicial review, which should minimize the Department's concerns about judicial review possibly leading to "chaotic results."

Diagnosis Related Groups

The latest or ICD-9-CM Diagnosis Related Groups (DRGs) will be used to define a hospital's case-mix and to establish a hospital's payment rates for Medicare beneficiaries. The plan proposes to use 356 of the 467 DRGs and to modify them to accommodate Medicare data.

The DRGs have proven to be an indicator of the types of inpatients treated and are useful for various pruposes. Users must realize, however, that the groups are not as medically meaningful nor as "homogeneous" as they might ostensibly appear to be. Our experences in New Jersey and our analyses of medical records and patients' bills have clearly demonstrated that most groups contain numerous patients with disparate medical needs. The heterogeneous nature of the groups is due partly to the fact that all diseases and illnesses were collapsed into 467 groups so the system would be manageable. The severity of a patient's illness is considered only to a limited extent, and no more than one complication or comorbid condition is used to assign patients to the DRGs.

The heterogeneous nature of the DRGs means that the groups are only approximations of a hospital's case mix. This nature may explain why DRG-based studies failed to find that public hospitals with a disproportionately large number of low income or Medicare patients treat patients who are sicker than average. In any event, the heterogeneous nature of the DRGs can easily cause many problems when hospitals are reimbursed on the basis of group averages.

Reimbursable Costs

The DRG payment rates are to include all historical inpatient costs exclusive of capital-related and medical education costs. These excluded costs will essentially be treated initially as pass throughs and Medicare will pay its full share of incurred costs.

Unlike the system now operational in New Jersey, the proposed plan does not specifically address how new costs incurred after the base year (presumably 1981) but before the rate year (1984) will be handled. The plan implies that a generic inflation adjustment will be used for this purpose. Yet the adjustment is apt to be wholly inadequate for many hospitals that added new beds and services, and did so under the aegis of an approved certificate of need. Also, as is the case in New Jersey, an amount must be included in the adjustment that recognizes how inflation limits a hospital's ability to replace capital assets. Hospitals must have a forum to seek reimbursement for these costs.

We are also concerned about the plan's silence concerning reimbursing hospitals for the implementation and ongoing costs that will definitely be required to report the necessary information and to manage under the new plan. DRG-based reimbursement will increase the cost of operating the medical record, billing, data processing, and other departments. Additional staff and equipment will be needed to collect, code, and process clinical and financial information. Hospitals must have access to computer technology to assign patients to the DRGs. The plan should ensure that hospitals will be paid for new regulatory costs just as was done in New Jersey when DRG-based reimbursement was launched. The plan should also indicate the types of information that hospitals must collect in order to cover their implementation costs.

Grave concern must also be expressed about the Department's refusal to reimburse uncompensated care, which consists of bad debts and the unpaid costs of caring for medically indigent people. Medicare has historically refused to pay for the uncompensated care associated with treating non-Medicare patients. Under New Jersey's tight plan, this cost is spread proportionately among all payers. The prospective plan should be modified to require Medicare to pay a share of these costs. Medicare's continued refusal to do so may jeopardize the ability of many hospitals, especially those in the inner city, to continue providing quality care, especially in light of Medicare cutbacks mandated by the Tax Equity and Fiscal Responsibility Act of 1982.

Payment Rates

The proposed plan would establish about 300 sets of DRG rates, one for each SMSA and non-SMSA area of the nation. The rates for any area would reflect the average cost of treating patients in given DRGs. These rates will apply to all hospitals in each area unless they receive an exemption or an adjustment. Specifically excluded from the plan are psychiatric, long term care and pediatric hospitals. The rates would represent full payment for Medicare inpatient services, with beneficiary cost-sharing restricted to legally-mandated co-payments. The rates will be paid for all Medicare patients except outliers--patients with atypical lengths of stay. Reimbursement for these patients *may* equal the DRG rates plus a percentage of charges for each day beyond the high outlier point.

Reimbursing all hospitals in an area at an average adjusted cost per DRG might be defensible if patients clustered around the average. The average would, in this case, be representative of the typical patient.

Data for New Jersey clearly show that in most DRGs, the average is unrepresentative of many, many patients. Hospitals may therefore suffer substantial losses for reasons outside their controls. Among the hospitals most likely to lose money are those that treat a disproportionate number of older, elderly patients and patients within a DRG who have more complicated, severe illnesses.

One reason why Medicare averages will be unrepresentative of typical patients will be the wide trim points used to identify outliers. Medicare proposes to use a method that will yield trim or cutoff points substantially wider than those used in New Jersey. To illustrate, the low and high trim points for DRG 1 are 6 and 36 days in New Jersey, but would have been roughly 6 to 84 days if the Medicare method had been used. As a result, the patients within the Medicare DRGs are likely to have much more heterogeneous medical needs than is the case in New Jersey. This problem can be minimized by narrowing the trim points.

New Jersey has minimized problems related to the unrepresentativeness of the DRGs by narrowing the trim (cutoff) points used to define outliers, or patients with atypical lengths of stay. In addition, five other classes of patients are treated as outliers, including patients in DRGs with fewer than 6 patients, patients in DRGs with poorly defined clinical characteristics, patients who discharge themselves against medical advice, and others. Approximately 30 percent of the patients in New Jersey hospitals were outliers in 1979. These patients accounted for about 25 percent of total hospital operating costs (Exhibits 1 and 2).

The plan speaks about average payment rates but does not indicate whether the average will be a mean or median. The difference is important because the median is about 7 percent below the mean. Use of the median would cause increased financial problems for hospitals and reduce the extent to which incentives are built into the program. Use of median averages would impose harsher penalties on hospitals with sicker than average patients.

The plan does not explain how 1981 rates will be rolled to 1984. It indicates that an inflation adjustment might be made that includes a 1 percent add-on designed to cover increases in the cost-per-Medicare discharge due to factors other than inflation. Among the possible noninflationary reasons why this cost could rise are new medical technology, increased intensity of care, new services, legally mandated changes, and the rising age of the elderly population. In the case of the first three possibilities, additional costs may be incurred under an approved certificate of need.

We are not aware of any study that demonstrates the adequacy or desirability of the one percent allowance. Indeed, recent studies conclude that the intensity of care alone rose roughly 3 to 4 percent per year for the decade ending in 1979. Therefore, the one percent is inadequate and will not meet the typical hospital's full financial requirements.

Even if the trim points are narrowed, many hospitals will incur financial hardship when all hospitals in an area are paid the same rates. In many cases, these rates will bear little relationship to a hospital's own cost for reasons outside its control. Given the heterogeneous nature of the DRGs coupled with the "radical" nature of per case reimbursement, the initial rates should be based on a hospital's own cost at the time it enters the new program. This will avoid the inherent problem of paying everyone at group averages while the fixed cap on spending forces hospitals to suppress spending.

New Jersey also minimizes problems related to the unrepresentativeness of the average rates by placing heavy reliance on a hospital's own cost in calculating the payment rates. Hospitals are therefore protected against problems related to the DRG grouping method. Furthermore, predicating payment rates on individual costs is no more expensive than paying everyone at the same average rate.

Basing the rates on actual costs will also respond to other problems with the rate calculations. For example, the Department's proposal does not make allowances for differences in hospital size, although cost usually varies directly with size because of enlarged service capacity. In addition, the grouping process ignores the fact that some hospitals may treat certain patients (e.g., psychiatric patients) in special units. The process also ignores the fact that hospitals with exactly the same Medicare DRG mix may have considerably different non-Medicare DRG patient mixes, which can have a marked effect on costs.

Unlike TEFRA, no automatic exception is granted to small rural hospitals. Because of the new reporting requirements and needed access to computer services, these hospitals should be allowed additional lead time to adjust to the new plan, if not exempted entirely. Payment of average rates may also be especially harmful to small hospitals. The reason lies partly in the fact that most DRGs often contain only a handful of patients. In New Jersey, where all patients are reimbursed DRG rates, and most hospitals have over 250 beds, approximately 100 of the 393 DRGs with acceptably defined clinical characteristics had around 500 patients statewide, or about 6 patients per hospital. About 70 percent had no more than 3000 patients, or 30 patients per hospital.

Another area of concern relates to the constraint that the plan proposes to place on DRG prices. Page 45 of the proposal states:

> "the actual level of prices initially will be determined by the constraint that the prospective payment system not increase Medicare outlays over the amount that would be spent were the present TEFRA system of limits continued."

The Tax Equity and Fiscal Responsibility Act tightened Medicare reimbursement significantly. To ratchet down from this reduced level at the same time that an entirely new payment plan is inaugurated introduces too many shocks into hospitals over a short time. This is also a dangerous approach because DRGs have not been tested on a national scale. Experiences with essentially 100 New Jersey hospitals suggest that many problems will arise during the startup year.

Error Rates

The proposed plan and an article in a recent HCFA journal (*Health Care Financing Review*, December 1982) report that the sample of bills in the MEDPAR file are replete with errors. Perhaps 20 to 30 percent of the bills in the MEDPAR file contain errors that may affect DRG assignment.

The Department makes the assumption that errors will to a large extent be self cancelling. In any event, adverse consequences of data errors can be minimized if the rates are initially based on a hospital's actual costs and payment is based on case mix in the rate year rather than case mix in the base year. Use of historical case mix will not allow for case-mix changes occurring between the base and rate years.

Furthermore, the Department's observation that "there is no evidence from New Jersey" that false coding of patients' medical records is a problem needs to be emphasized. Hospitals have been criticized unjustly for taking meticulous steps to code properly. Under perdiem reimbursement systems the diagnosis codes did not determine reimbursement. As soon as they do--as can be expected--every legitimate effort will be taken to scrutinize this area of a hospital's operation. The fact should be emphasized that there is no indication in New Jersey of the phenomenon labelled "DRG creep" or coding up to enhance reimbursement.

Implementation Time

The Department of Health and Human Services has indicated that it could begin implementing its plan on October 1, 1983. Hospitals would be brought into the program based on their cost reporting period.

Because of problems inherent in a uniform startup date, we agree that hospitals should be phased into the program based on their cost reporting periods. However, it is absolutely essential for hospitals to have sufficient lead time, at least 6 months, to learn about the program, adopt the requisite changes necessary to meet the regulations, and to educate staff about what is expected from them under this entirely new system of reimbursement. Widespread confusion will result if the plan is implemented too rapidly. The consequences are apt to spill into the future insofar as hospitals are unable to collect information needed for reimbursement.

Reporting Requirements

One of the Department's objectives is to reduce Medicare reporting requirements. New Jersey experiences suggest that the paperwork hospitals face will increase considerably under DRG-based reimbursement. In short, any reduction in Medicare reporting requirements may easily be overpowered by information hospitals must collect and have to operate under the program.

Details of the Plan

There is merit in many of the components in the proposed plan. We are concerned, however, that important details of the Department's proposal are missing. This limits the ability of hospitals to comment on the proposal and to gauge its financial impact. The following are indicative of some of the missing details:

- The plan does not describe the adjustment methodology that will be used to pay teaching hospitals the same DRG rates as other hospitals.
- The plan does not indicate whether mean or median costs per Medicare discharge will be used to establish DRG prices. As I stated earlier, median rates would be about 7 percent lower than mean rates.
- The plan does not explain how the rates will be adjusted for technologic developments occurring between the base and rate years.
- The plan does not indicate how or how often the DRG prices will be calculated after the first year.
- The plan does not explain how base year costs will be rolled forward to establish future rates.

- The plan does not explain how outliers will be identified and reimbursed, an omission that is especially important for small hospitals.
- The plan does not explain how hospitals will be paid for patients who were admitted in one year and discharged the following year.
- The plan does not indicate what types of exceptions and adjustments would be granted to sole community providers.
- The plan does not indicate whether an annual technology allowance will be added to the rates.

Apart from missing details, in at least two places the plan seems contradictory. These problems may have important financial implications. First, page IV states that "all patients can be categorized into one of 467 different groups," while page 43 indicates that "the category definitions cover virtually the entire patient population." The latter statement is correct. As presently constructed, patients with an operating room procedure unrelated to the principal diagnosis are assigned to DRG 468, one of three catchall DRGs. About 5 percent of the MEDPAR file falls into DRG 468. The proposal must address how these patients will be reimbursed.

Second, rate calculation schemata on page 81 indicate that 1981 costs adjusted for inflation and other factors will be used to set 1984 rates. Yet, according to page 45 Medicare payments will be limited to "the amount that would be spent were the present TEFRA system of limits continued." These two approaches may yield significantly different payments.

In conclusion, Mr. Chairman, I hope these comments will prove useful to this committee as it considers this proposal and others such as the American Hospital Association's prospective plan. We commend these efforts and these hearings as an attempt to develop an equitable, effective reimbursement system. We are proud of our accomplishments in New Jersey in serving as a "laboratory" for the nation in testing new systems. We reiterate our sincere offer to share what we have learned and stand ready in this capacity to assist this committee in any way we can.

I would be pleased to answer any questions you may have.

Exhibit 1

PERCENT DISTRIBUTION OF INPATIENTS

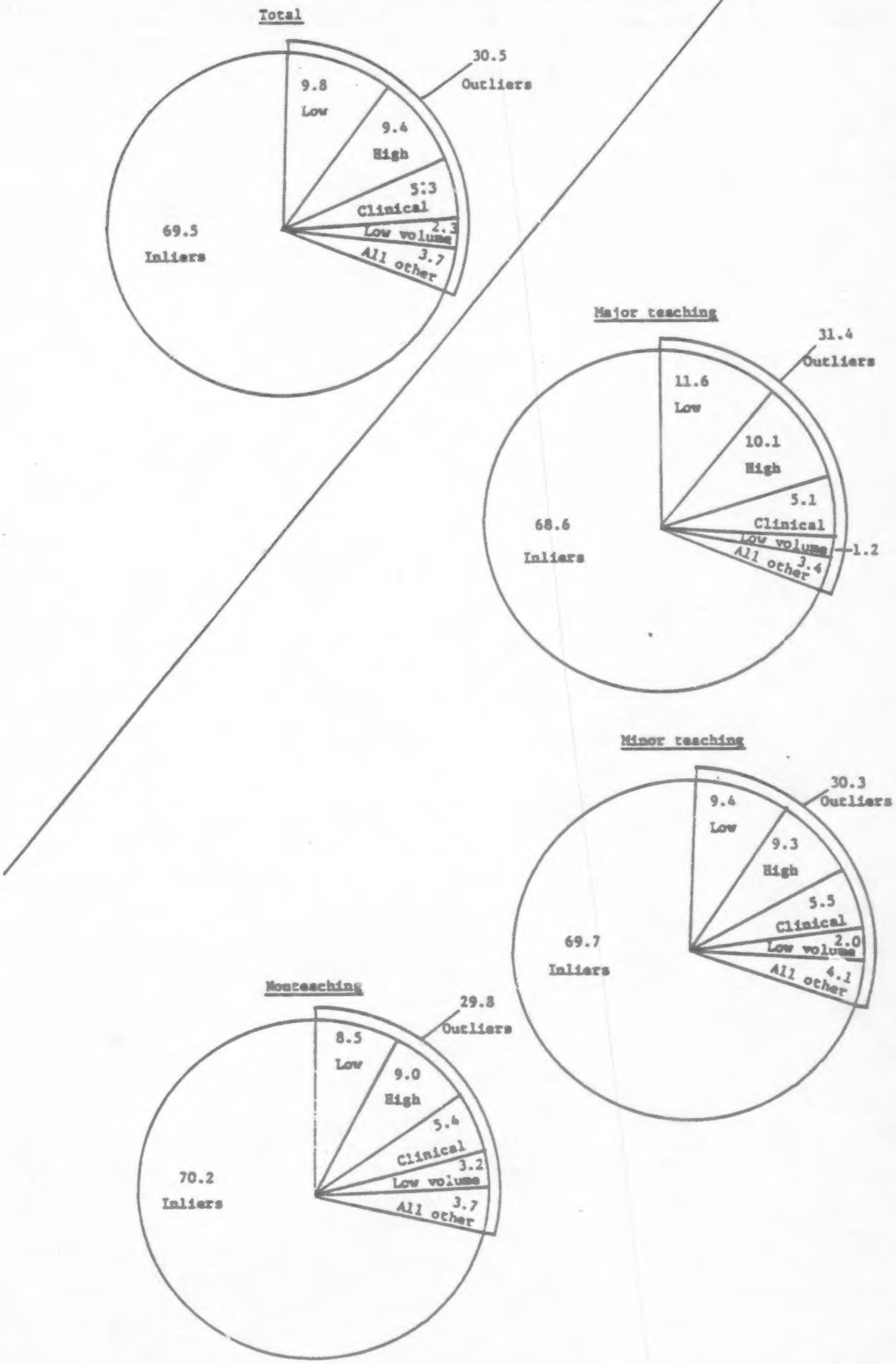
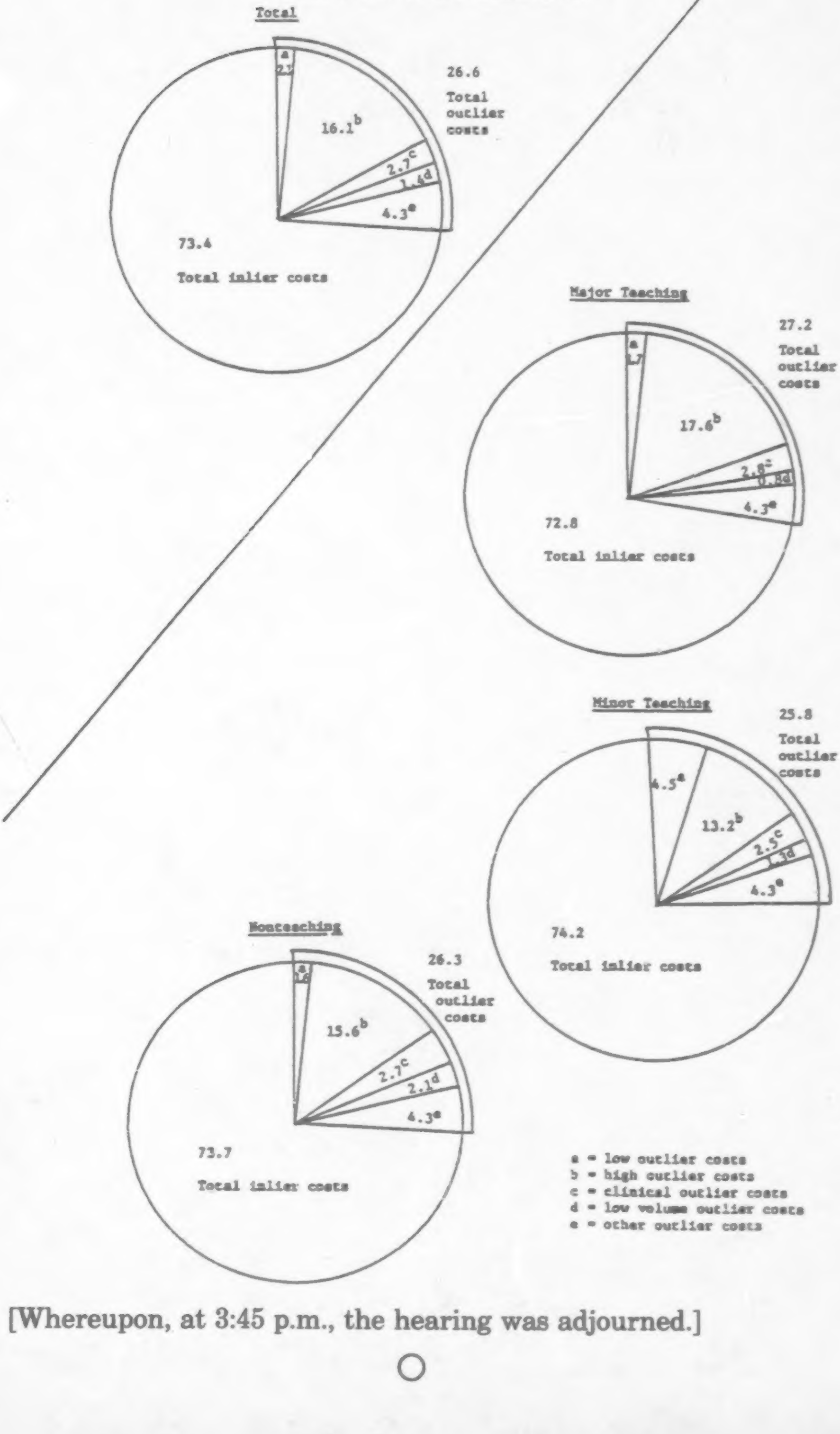


Exhibit 2

OUTLIER COSTS AS A PERCENT OF TOTAL COSTS
(includes incentives & disincentives)



[Whereupon, at 3:45 p.m., the hearing was adjourned.]

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